Section 3: Forms

FORMS

Introduction

The Denti-Cal claims processing system involves the use of the following interrelated forms:

- Claim – DC-002A, DC-009A, DC-017A
- Treatment Authorization Request (TAR) – DC-002B, DC-009B, DC-017B
- Notice of Authorization (NOA) – DC-101
- Resubmission Turnaround Document (RTD) – DC-102
- Claim Inquiry Form (CIF) – DC-003

Due to changes in technology, the following claims and TAR forms are no longer available: DC-001A, DC-001B, DC-001C, and DC-001D. It is rapidly becoming impossible for these forms, with attached X-ray envelopes, to be imprinted and still meet the requirements of the now-automated U.S. Postal Service. Denti-Cal's forms warehouse has been instructed to no longer fill inventory requests for these forms.

Denti-Cal encourages provides to destroy any inventory of the outdated forms and ensure that sufficient quantity of which ever alternative forms and envelopes best meet the needs of the office are available.

Proper use and completion of these forms will expedite authorization or payment for Denti-Cal covered services. ***Denti-Cal will only accept original State-approved forms. No duplicates or photo copies will be accepted or processed. Any claim service line (CSL) submitted with an invalid procedure code or a blank procedure code field will be denied, whether submitted electronically or as paper documents.***

Ordering Forms

When ordering forms, be sure to request an adequate supply of Claim forms, TAR forms, CIFs, Periodontal Evaluation Charts and Justification of Need for Prosthesis forms, plus x-ray and mailing envelopes. Denti-Cal Forms Reorder Request (DC-004) is to be used to order forms from the Denti-Cal's forms supplier.

Do not send requests for forms directly to Denti-Cal. The Denti-Cal Forms Reorder Request should be mailed or faxed to the warehouse vendor:

Shamrock Companies, Inc.
410 E. Grantline Road
Tracy, CA 95376
(209) 832-2105

Please refrain from sending these requests to Denti-Cal as forms are only warehoused at the print vendor's location. Also, please do not submit phone orders to the warehouse as they are not staffed to handle telephone requests.

The Claim and Treatment Authorization Request (TAR) Forms

The Claim form and the TAR form are two separate forms. The Claim form is used to submit a claim for payment of services performed. The blue TAR form is used to request authorization of proposed treatment. Accurate completion of these forms is required to ensure proper and expeditious handling by Denti-Cal. An incomplete or inaccurate Claim or TAR form will delay processing and may result in the generation of a RTD. The RTD will be sent to the dental office to request additional or corrected information needed to process the claim or TAR.

The Denti-Cal Claim and TAR forms are the only treatment forms that can be processed under the California Medi-Cal Dental Program for payment or authorization of covered services.

The format of the Claim and TAR forms is similar:

- **DC-002A and DC-002B** (No Carbon Required (NCR) Claim and TAR forms):
- **DC-009A and DC-009B** (continuous Claim and TAR forms):

  Page 1 - Original: Submit this copy to Denti-Cal.

Page 2 - Carbon Copy: Dentist's office copy.

- **DC-017A and DC-017B** (single-sheet Claim and TAR forms for use in laser printers).

Denti-Cal offers the following special envelopes to be used by the dental office for enclosing x-rays with computerized claim and TAR forms:

- **DC-014A** - Large x-ray envelope for computer claims DC-009A and DC-017A
- **DC-014B** - Large x-ray envelope for computer TARs DC-009B and DC-017B
- **DC-014C** - Standard x-ray envelope submitted with computer claims DC-009A and DC-017A.
- **DC-014D** - Standard x-ray envelope submitted with computer TARs DC-009B and DC-017B
- **DC-014E** - Large x-ray envelope for EDI documents
- **DC-014F** - Standard x-ray envelope for EDI documents

X-rays should be placed in these envelopes when submitting them with computerized forms. Loose x-rays can become separated and lost, which can delay the time it takes Denti-Cal to process your document.

Denti-Cal also provides the following envelopes for mailing your Claim and TAR forms:

- **DC-006A** - Large envelope with green border for mailing claims
- **DC-006B** - Large envelope with blue border for mailing TARs
- **DC-006C** - Large envelope with red border for mailing EDI documents

How to Complete the Claim Form or TAR Form

Denti-Cal implemented new claims processing technology in June 2005, replacing current microfilm and key data entry functions with imaging, Optical Character Recognition (OCR) and data correction. Our goal is to improve processing time, improve responsiveness to provider and beneficiary inquiries, and increase adjudication accuracy.

OCR technology allows for a more automated process of capturing information from paper documents and enables us to electronically adjudicate paper forms. Please note: OCR has been set up to "read" *any* mark in boxes 11 through 18 as a "yes," even if the answer is "no." So please do *not* check boxes 11, 12, 13, 14, 15, 16, 17 or 18 unless indicating "yes."

To ensure optimum results, we ask that you follow the specifications listed below. Following the items in the "Do Not" section will not cause your paper form to deny, however it may require more manual intervention and take longer to process.

- **DO** use a laser printer for best results (if you must print information use neat block letters that stay within field boundaries)
- **DO** use the most current Denti-Cal claim forms (DC-002A, DC-009A, or DC-017A) and Treatment Authorization Request forms (DC-002B, DC-009B, or DC-017B)
- **DO** use black ink
- **DO** use all capital letters
- **DO** use non-proportional fonts (Courier is a good example of a non-proportional font)
- **DO** use a 10-point font if possible
- **DO** use an 8-digit date format, e.g., 10212005
- **DO** print data within the defined boxes on the form and always enter quantity information in the quantity field only
- **DO** only use white correction tape for corrections
- **DO** always submit notes on 8½" x 11" paper
- **DO** always submit information on one side of the paper only
- **DO** always apply a handwritten signature
- **DO NOT** use a dot matrix/impact printer
- **DO NOT** use the DC-001A, DC-001B, DC-001C, DC-001D, with attached x-ray envelopes (these forms should be discarded)
- **DO NOT** use proportional fonts, italics or script fonts
- **DO NOT** mix fonts on the same form
- **DO NOT** use fonts smaller than 10 point
- **DO NOT** use arrows or ditto marks to indicate duplicate dates of service, rendering provider ID, etc.
- **DO NOT** use dashes or slashes in date fields
- **DO NOT** print slashed zeros
- **DO NOT** use correction fluid
- **DO NOT** use photocopies of claim forms
- **DO NOT** use highlighters to highlight field information as this causes field data to turn black and become unreadable
- **DO NOT** submit two sided attachments
- **DO NOT** enter quantity information in the description of service field
- **DO NOT** put notes on the top or bottom of forms
- **DO NOT** fold claim forms
- **DO NOT** use labels, stickers, or stamps on claims/Treatment Authorization Request forms
- **DO NOT** use rubber signature stamps or "signature on file"

Accurate and complete preparation of these forms (Figures 3-1 and 3-2) is essential for processing. Unless otherwise specified, all fields must be completed. Since the Claim and TAR forms are so similar, the following instructions apply to both. Please enter all dates using six (6) numerical digits, e.g., mm/dd/yy.

Denti-Cal's evaluation of TARs and claims will be more accurate when narrative documentation is included. The following reminders and tips help office staff prepare narrative documentation for some common Denti-Cal procedures:

- The "Comments" area (box 34) of the treatment form is the best place to write narrative documentation. If including narrative documentation on a separate piece of paper, be sure to check box 10 on the treatment form to indicate there are other attachments. It is also helpful to note in

area 34 that written comments are attached.

- Repeated use of "pattern" documentation for the same procedure is not acceptable. Narrative documentation should always state the facts that pertain to the specific situation.
- When submitting a request for a procedure that involves a partial denture, always include the type of partial denture, i.e., Procedure 702, 703 or 708.
- Be sure to include the arch code (u = upper, l = lower) when requesting payment for denture repairs and adjustments. Documentation is required for repairs.
- Remember the following three things when documenting Procedures 020 (office visit for observation), 080 (emergency palliative) and 451 (emergency periodontal):
  1. the patient's complaint;
  2. the diagnosis, including tooth number or area of involvement;
  3. the specific treatment provided.
- Documentation for Procedure 720 (denture adjustment) *must* include the arch code and the location of the adjustment, e.g., "left buccal flange," "lingual of area #9," et cetera.
- If a surgical extraction was necessary to remove a tooth but the preoperative x-rays depict a simple extraction procedure, include narrative documentation to justify Procedure 202.
- Submit all x-rays taken for root canal treatments and crown requests. Sometimes additional views are taken at different angles, which may be helpful in determining the necessity of the requested procedure.
- Evaluation of laboratory processed crowns (Procedures 650-663) is enhanced by documentation that includes the extent of the decay and the specific cusps involved.
- Remember that narrative documentation should be legible; printed or typewritten documentation is always preferred. Be sure to change typewriter or computer printer ribbon frequently and try to avoid strikeovers, erasures or using correction fluid when printing or typing narrative documentation on the treatment form (Box 34).
- If submitting electronically, abbreviate comments to make optimum use of allotted space.

Fill in each field as follows:

1. **PATIENT NAME:** Enter the patient's last name, first name and middle initial.
2. **PATIENT SOCIAL SECURITY NUMBER:** Enter the Social Security number of the patient, if known.
3. **PATIENT SEX:** Check "M" for male or "F" for female.
4. **PATIENT BIRTHDATE:** Enter the patient's birthdate. The birthdate is used to help identify the patient. Differences between the birthdate on the Medi-Cal Identification Card and the birthdate given by the patient should be brought to the attention of the patient for correction by his/her County Social Services office.
5. **PATIENT MEDI-CAL IDENTIFICATION NUMBER:** Enter the patient's 10-digit State Recipient Identifier as it appears on the Medi-Cal identification card. Completion of this field is required.
6. **PATIENT ADDRESS:** Enter the patient's current address. If the patient resides in a convalescent home or other health care facility, indicate the full name, complete address and phone number, including area code, of the convalescent home or other health care facility.

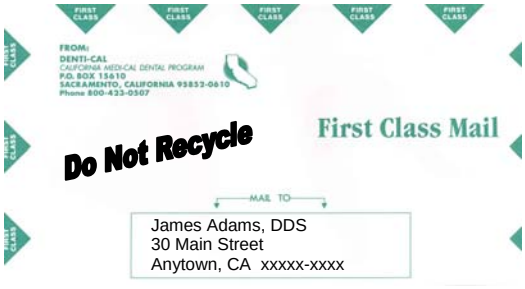
   Please Note: It is important to accurately document the patient's name, social security number, birthdate, Medi-Cal identification number and address when submitting billing forms to Denti-Cal. Denti-Cal may need to contact the patient for screening, and if the patient's information is incorrect, it can cause delays in processing the document.
7. **PATIENT DENTAL RECORD NUMBER:** If you assign a Dental Record Number or account number to a patient, enter the assigned number here. The number will then appear on all related correspondence from Denti-Cal.

8. **REFERRING PROVIDER NUMBER:** Enter the license number of the dentist who referred the patient to your office, if applicable.

9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the number of films enclosed. All radiographs and any attachments should be clearly identified with the patient's name and social security number, the date that the x-ray was taken, and the provider's name and provider number.

   Four or more multiple x-rays must be mounted. If the x-rays are unmounted or undated, the request for authorization or payment will be denied. It is acceptable to submit three or less radiographs unmounted, but the envelopes in which these x-rays are submitted must be dated. X-rays taken on different days must be submitted in different dated envelopes. Be sure to document in the Comments area of the claim (box 34) any condition that cannot be viewed on the x-ray.

   Radiographs and photographs are no longer automatically returned. If you want x-rays returned, it is imperative that the preimprinted or typed return address **x-ray envelopes** be used, with the address clearly legible. ***Providers must indicate "Do Not Recycle" only on the front of envelopes specifically used for x-rays – DC-014A, -014B, -014C, -014D, -014E, -014F – as seen in the following example:***



   Many providers are erroneously indicating "Do Not Recycle" on the outside of the claim submission envelope. This results in radiographs and photographs not being returned.

   "Do Not Recycle" stickers are available free of charge from the Denti-Cal's forms supplier. They may be ordered by marking the DC-020 box on the Forms Reorder Request form and faxing the form to (209) 832-2105.

10. **OTHER ATTACHMENTS:** Check "yes" if additional documents are attached to the claim or TAR form. Examples of other attachments include related correspondence, periodontal charts, operating room reports or physician's report describing the patient's specific medical condition. If the physician's report is concerning a homebound patient, be sure to document the reason the patient cannot leave the private residence and the length of time the patient will be homebound. Do not place attachments inside the x-ray envelope.

11. **ACCIDENT/INJURY? EMPLOYMENT RELATED?** Check "yes" if the patient was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the patient's accident or injury was caused by or occurred at work, check "yes."

12. **ELIGIBILITY PENDING? (FOR TAR ONLY)** Check "yes" if the patient has applied for Medi-Cal eligibility which has not yet been approved and you wish to submit a TAR for that patient.

13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private- or employer-paid dental insurance carrier. You must bill the other insurance carrier prior to submitting the claim to Denti-Cal. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name, Social Security number and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits or denial letter. For more information on other coverage, see Section 2 of this manual.

14. **MEDICARE DENTAL COVERAGE?** Check "yes" if the service performed is covered by Medicare. Medicare must be billed prior to submitting any Medicare-covered service to Denti-Cal. Attach a

copy of the Explanation of Medicare Benefits form or denial letter.

15. **RETROACTIVE ELIGIBILITY?** Check "yes" if the services have been performed and the provider is requesting payment for the reason described in the "COMMENTS" section, field 34.

16. **CHDP (CHILD HEALTH AND DISABILITY PREVENTION)?** Check "yes" if the treatment is related to a previous CHDP screening. The CHDP Children's Treatment Program (CTP) claims must be submitted with a current PM 160 (health assessment screening form) attached to the Denti-Cal claim form. In the event the patient's social security number is known, please include the social security number in field 2 on the claim form.

17. **CCS (CALIFORNIA CHILDREN SERVICES)?** Check "yes" if any services performed are authorized by CCS.

18. **MF-O (MAXILLOFACIAL-ORTHODONTIC) SERVICES?** Check "yes" if the claim is for maxillofacial-orthodontic services.

19. **BILLING PROVIDER NAME:** Enter the billing provider's name in either the "doing business as" format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.

20. **BILLING PROVIDER NUMBER:** Enter the billing provider's Medi-Cal Provider Number. NOTE: The Medi-Cal Provider Number and correct service office (where the services were administered) must be present and correct on all forms.

21. **BILLING PROVIDER ADDRESS AND TELEPHONE NUMBER:** Enter the service office address where treatment is rendered. A service office address should be a street address, including city, state and zip code. A post office box cannot be used as a service office; however, it is acceptable *in rural areas only* to use a route number with a post office box number.

    If the service office address is different from the address where you receive payment, please be sure to notify Denti-Cal so payment can be directed to the appropriate location.

    It is important to include the telephone number of the service office, including area code, so Denti-Cal can contact you in case any questions arise while processing your document.

    Please Note: It is important that the billing provider's name, Medi-Cal billing number, address and telephone number are accurate and match the information Denti-Cal has recorded on its system. Claim and TAR forms that are pre-printed with the provider's name/number/address are available at no charge from the Denti-Cal forms supplier. Please check this information for accuracy on all pre-printed supplies. If you are using forms printed from your office computer, please be sure the computer is programmed with the correct provider information.

22. **PLACE OF SERVICE:** Check the appropriate box indicating where service was performed (claim) or will be performed (TAR)-Office, Home, Clinic/Dental School Clinic, SNF (Skilled Nursing Facility), ICF (Intermediate Care Facility), Hospital In-Patient, Hospital Out-Patient, Other (specify place of service). Those providers treating an SNF or ICF beneficiary outside the facility in which they reside, either in a mobile van at the facility or in the provider's office, must indicate place of service 8 in box 22.

23. **POE (PROOF OF ELIGIBILITY) AREA:** This area is only used to record the new issue date for Benefits Identification Cards (BICs).

24. **EXAMINATION AND TREATMENT:** This area is designed to indicate what treatment was performed or requested. Accurate and complete information in these fields is vital. List treatment in tooth number sequence. Use one line to describe each separate service performed or requested.

25. **TOOTH IDENTIFICATION CHART:** Use an "X" to indicate missing permanent teeth (excluding unerupted third molars) on the tooth chart. Radiographs that clearly depict all areas of both the maxillary and

mandibular arches will substitute for the charting requirement. (Note: Charting of missing teeth for children age zero thru six years is not required.) Periodontal Evaluation Charts (DC-008) can be ordered through the Denti-Cal forms supplier.

26. **TOOTH NUMBER OR LETTER; ARCH; QUADRANT:** Use universal tooth code numbers 1 thru 32 or letters A thru T for tooth reference. Use arch code "U" (upper), "L" lower). Use quadrant code "UR" (upper right), "UL" (upper left), "LR" (lower right), and "LL" (lower left).

27. **TOOTH SURFACES:** Use "M" (mesial), "D" (distal), "O" (occlusal), "I" (incisal), "L" (lingual or palatal), "B" (buccal), and "F" (facial).

28. **DESCRIPTION OF SERVICE:** Furnish a brief description for each service. Standard abbreviations are acceptable.

29. **DATE SERVICE PERFORMED:** (for payment claims only) Indicate the date the service was performed, using the six (6) numerical digits e.g., mm/dd/yy.

30. **QUANTITY:** For the procedures having multiple occurrences, indicate the number of occurrences of the procedure, e.g., multiple radiographs (Procedure 111), units for prosthetic procedures (Procedure 716), or number of pins (Procedure 648).

31. **PROCEDURE NUMBERS:** Use a Denti-Cal three-digit, State-approved four-digit or State-approved five-digit code for each service. *Note:* Do not mix the different types of codes when completing a claim or TAR form as this will delay processing.

32. **FEE:** Enter your usual and customary fee for the procedure rather than the Denti-Cal Schedule of Maximum Allowances fee.

33. **TREATING MEDI-CAL PROVIDER NUMBER: FOR PAYMENT CLAIMS ONLY.** If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the treating provider number of the dentist or dental hygienist who performed the service. The treating provider number should be entered on the claim line for each service performed. The alpha character "D" should precede the number e.g., D-2-3-4-5-6.

    A treating provider number is not needed for the following procedures: 045, 046, 049, 050, 061, 062, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 125, 160, 955, 956 and 957.

    IF THERE IS ONLY ONE DENTIST OR DENTAL HYGIENIST TREATING PATIENTS AT A SERVICE OFFICE, THE FIELD "TREATING MEDI-CAL PROVIDER NUMBER" DOES NOT NEED TO BE COMPLETED FOR ANY CLAIM LINE.

34. **COMMENTS:** Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. Narrative documentation should always state facts as they pertain to the case. Printed or typewritten documentation is preferred. It is helpful to note in this area that narrative documentation is attached when you are including narrative documentation on a separate piece of paper.

    If your office is submitting a claim for a patient restricted to emergency services, the emergency certification statement can be entered in this area or attached to the claim form. This statement is required for emergency services. It must describe the nature of the emergency, including clinical information pertinent to the patient's condition, and explain why the emergency services were immediately necessary. This statement must be signed by the provider.

    When preparing a TAR for a beneficiary with an authorized representative who is not identified on the Medi-Cal card, please include the representative's name and address in this area on the TAR form. This will assist Denti-Cal in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information.

    This area should also be used to indicate the:

    - eligibility confirmation number given by the AEVS when verifying eligibility for your patient.

- ♦ name, address and telephone number of the Skilled Nursing Facility or Intermediate Care Facility for the Developmentally Disabled.

35. **TOTAL FEE CHARGED:** The sum of the fees entered in field 32 for all lines.

36. **PATIENT SHARE-OF-COST AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of the patient's share-of-cost collected by or due to your office from a recipient who has a share-of-cost obligation.

37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of "other coverage" payments the provider has received for the listed procedures. If either field 13 (OTHER DENTAL COVERAGE) or field 14 (MEDI-CARE DENTAL COVERAGE) is checked "yes", the amount received from the private dental insurance carrier or Medicare must be entered. The Explanation of Benefits (EOB) or denial from the private dental insurance carrier or Medicare must be attached to the claim for payment.

38. **DATE BILLED:** Enter the date the form is mailed using six (6) numerical digits, e.g., mm/dd/yy.

39. **SIGNATURE BLOCK:** The provider, or person authorized by the provider, must sign his/her own name in this signature box and date the form when requesting prior authorization or payment. ***Rubber stamp signatures are not acceptable.***

After providing all necessary information on the form please follow these steps:

1. Detach the "Dentist Copy" (page 2, where applicable) and retain for your records. Discard carbon paper.

2. Check page 1 for completeness and legibility.

3. Place attachments, if any, behind the form or the x-ray envelope. Staple them to the back of the form, in the upper right corner. Only staple the attachments once to the form. Excessive staples will delay processing.

4. Mail completed **white Claim forms** in the large **green-bordered mailing envelopes** that have been provided. Up to 10 forms can be mailed in a single envelope.

   Mail completed Claim forms to:

   Denti-Cal
   California Medi-Cal Dental Program
   P.O. Box 15610
   Sacramento, CA 95852-0610

   Do not send completed claims and TARs in the same envelope.

5. Mail completed **blue TAR forms** in the large **blue-bordered mailing envelopes** that have been provided. Up to 10 forms can be mailed in a single envelope.

   Mail completed TARs to:

   Denti-Cal
   California Medi-Cal Dental Program
   P.O. Box 15540
   Sacramento, CA 95852-1540

   Do not send completed claims and TARs in the same envelope.

6. If you are submitting **a claim and TAR together for the same patient that requires the same documentation**, staple them together in the upper right corner and mail the forms in the **blue-bordered TAR envelopes**.

   Please Note: Photocopies or the "Dentist's Copy" of the original are never acceptable for processing. Be sure to sign and mail the original document.

Denti-Cal must receive a claim for full payment (100 percent of the SMA amount) of services no later than six months after the end of the month in which the services were performed. Claims received six to nine months after the end of the month in which the services were performed will be considered for payment at 75 percent of the SMA amount. Claims received ten to twelve months after the end of the month in which the services were performed will be considered for payment at 50 percent of the SMA amount. Claims received more than twelve months after the end of the month in which the services were performed will not be considered for payment. This billing limitation policy applies to each completed date of service.

Figure 3-1
SAMPLE CLAIM FOR PAYMENT

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone 800-423-0507

CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)	2. PATIENT SOC. SEC. NO.	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. PATIENT MEDI-CAL I.D. NO.
Last Name, First Name	999-99-9999	x	mm / dd / yyyy	9999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
address	
CITY, STATE — address — ZIP CODE	8. REFERRING PROVIDER NUMBER

9. CHECK IF RADIOGRAPHS ATTACHED?	YES	11. CHECK IF ACCIDENT/INJURY?	YES	13. CHECK IF OTHER DENTAL COVERAGE?	YES	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? CHECK IF	YES
HOW MANY? _____		EMPLOYMENT RELATED?	YES	14. MEDICARE DENTAL COVERAGE?	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)	20. MEDI-CAL PROVIDER NUMBER
Adams, James DDS	Gxxxxx-01
21. MAILING ADDRESS: 30 Main Street	TELEPHONE NUMBER: (XXX)XXX-XXXX
CITY, STATE: Anytown, CA	ZIP CODE: XXXXX-XXXX

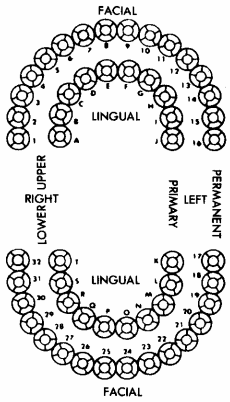
22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
x	2	3	4	5	6	7	8

PLEASE AFFIX P.O.E. LABELS IN THIS BOX IN CHRONOLOGICAL ORDER

P.O.E.

25. IDENTIFY MISSING TEETH WITH "X"



24. EXAMINATION AND TREATMENT - LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32

26. TOOTH NO. OR LETTER ARCH	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY.	31. PROCEDURE NUMBER	32. FEE	33. TREATING MEDI-CAL PROVIDER NO.
		1 exam	9/10/01		010	$25.00	D12345
		2 4 BW X-rays	9/10/01		117	$20.00	
		3 prophy	9/10/01		050	$45.00	
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

Sample

34. COMMENTS

35. TOTAL FEE CHARGED	$90.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	09/13/01

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X James Adams, DDS — SIGNATURE
9/13/01 — DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your Claim an X-Ray Envelope containing your X-Rays **MUST** be attached to this form. The X-Ray Envelopes (DC 014A and DC 014C) are available free of charge from the Denti-Cal Forms Supplier.

[redacted]

DC-017A (R4/96)

DENTI-CAL COPY

Figure 3-2
SAMPLE TAR (BLUE)

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15540
SACRAMENTO, CALIFORNIA 95852-1540
Phone 800-423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)

1. PATIENT NAME (LAST, FIRST, M.I.)	2. PATIENT SOC. SEC. NO.	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YR	5. PATIENT MEDI-CAL I.D. NO.
Last Name, First Name	999-99-9999	x	mm / dd / yyyy	9999999999

6. PATIENT ADDRESS	7. PATIENT DENTAL RECORD NUMBER
address	
CITY, STATE — address — ZIP CODE	8. REFERRING PROVIDER NUMBER

9. CHECK IF RADIOGRAPHS ATTACHED?	YES	11. CHECK IF ACCIDENT/INJURY?	YES	13. CHECK IF OTHER DENTAL COVERAGE?	YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION?	YES
HOW MANY? _____		EMPLOYMENT RELATED?	YES	14. MEDICARE DENTAL COVERAGE?	YES	17. CCS CALIFORNIA CHILDREN SERVICES?	YES
10. OTHER ATTACHMENTS?	YES	12. ELIGIBILITY PENDING? (SEE PROVIDER MANUAL)	YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER MANUAL)	YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES?	YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)		20. MEDI-CAL PROVIDER NUMBER
Adams, James	**DDS**	**Gxxxxx-01**
21. MAILING ADDRESS		TELEPHONE NUMBER
30 Main Street		**(xxx) xxx-xxxx**
CITY, STATE		ZIP CODE
Anytown, CA		**xxxxx-xxxx**

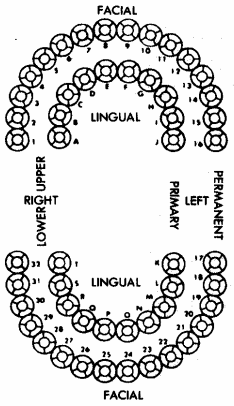
PLEASE AFFIX P.O.E. LABELS
IN THIS BOX IN CHRONOLOGICAL ORDER

P.O.E.

22. PLACE OF SERVICE

OFFICE	HOME	CLINIC	SNF	ICF	HOSPITAL IN-PATIENT	HOSPITAL OUT-PATIENT	OTHER (PLEASE SPECIFY)
1	2	3	4	5	6	7	8

25. IDENTIFY MISSING TEETH WITH "X"



24. **EXAMINATION AND TREATMENT** - LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32

26. TOOTH NO. OR LETTER ARCH	27. SURFACES		28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QTY.	31. PROCEDURE NUMBER	32. FEE	33. TREATING MEDI-CAL PROVIDER NO.
	U	1	Lab Reline			722	$200.00	
	L	2	Lab Reline			722	$200.00	
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
		12						
		13						
		14						
		15						

Sample

34. COMMENTS

35. TOTAL FEE CHARGED	$400.00
36. PATIENT SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	10/24/01
38. DATE BILLED	

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X *James Adams, DDS* *10/24/01*
SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your TAR an X-Ray Envelope containing your X-Rays **MUST** be attached to this form. The X-Ray Envelopes (DC 014B and DC 014D) are available free of charge from the Denti-Cal Forms Supplier.

[redacted]

DC-017B (R6/96) PRINTED ON RECYCLED PAPER

DENTI-CAL COPY

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The Notice of Authorization (NOA)

The NOA (Figures 3-3a and 3-3b), a computer-generated form sent to the provider following final adjudication of a TAR, is printed with the same information as originally submitted. Presently the NOA is used either to request payment of allowed services or to request a re-evaluation of modified or denied services on a TAR.

NOAs issued for beneficiaries with Aid Code 50, 8F, 84, 85, 88, and 89, will list the following informational message:

> Please note: This beneficiary may only be eligible for reduced CMSP benefits. Please verify eligibility and allowable procedures prior to rendering services.

Providers may request a re-evaluation period of 180 days for denied and/or additional procedures requested in certain instances. Changes to the billed amount or procedures not requiring prior authorization will *not* be considered. Orthodontic treatments continue to be excluded from this change.

Re-evaluations may be allowed when

- another procedure requiring prior authorization has been requested
- there is a reversal of denied procedures, e.g., missing x-rays have been submitted.
- there is a complex treatment plan

Denti-Cal has created the following NOA message when a re-evaluation has been requested:

> The submitted changes have been reviewed. Original authorization period still valid.

Denti-Cal has revised the following NOA message when a re-evaluation has been requested:

> Resubmission not processed. No additional information received. Original authorization period still valid.

To expedite processing and prevent delays or possible denial, please remember to check the box found in the upper right corner of the NOA. ***Only one re-evaluation may be requested per NOA and it must be received prior to the expiration date.***

Prior to completing the form, verify that the information printed on the form is correct.

The NOA is printed by Denti-Cal with the following information:

1. Authorized period of time (180 days)
2. Patient information (except Medi-Cal ID Number)
3. Provider information
4. Procedures allowed, modified, disallowed
5. Allowances
6. Adjustment codes

Denti-Cal will indicate on the NOA if the services requested are allowed, modified or disallowed. For those allowed services, fill in the appropriate shaded areas on the top portion of the NOA form. Submit the completed and signed form, marked "DENTI-CAL COPY," as a claim for payment for the services performed. Also, fill in the appropriate shaded areas on the "DENTIST COPY" and retain this copy for your records.

The NOA has a statement printed on the bottom of the form that reads: "NOTE: Authorization does not guarantee payment. Payment subject to patient's eligibility." This statement has been added to remind the dentist to verify the patient's eligibility prior to providing services.

If the allowed period of time on your NOA has expired and none of the authorized services have been completed, please send the expired NOA back to Denti-Cal so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

How to Complete the NOA

The following fields on the NOA require completion by the dental office. The required fields are listed in the order that they appear on the NOA.

5. **PATIENT MEDI-CAL IDENTIFICATION NUMBER:** Enter the patient's 10-digit State Recipient Identifier as it appears on the Medi-Cal identification card (Benefits Identification Card). Completion of this field is required.
9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the

number of films enclosed. All radiographs and any attachments should be clearly identified with the patient's name and social security number, the date the x-ray was taken, and the provider's name and provider number.

Four or more multiple x-rays must be mounted. If the x-rays are unmounted or undated, the request for authorization or payment will be denied. It is acceptable to submit three or less radiographs unmounted, but the envelopes in which these x-rays are submitted must be dated. X-rays taken on different days must be submitted in different dated envelopes. Be sure to document in the Comments area of the claim (box 34) any condition that cannot be viewed on the x-ray.

Final treatment x-rays of endodontic treatment are necessary when submitting for payment of Procedure 511 (Anterior Root Canal Therapy), Procedure 512 (Bicuspid Root Canal Therapy), Procedure 513 (Molar Root Canal Therapy), Procedure 530 (Apicoectomy-Surgical procedure in conjunction with root canal filling), and Procedure 531 (Apicoectomy-Separate surgical procedure).

If additional treatment not requiring prior authorization is added to the NOA, x-rays or narrative documentation must be submitted, as appropriate, to justify the additional service.

Denti-Cal recycles *all* radiographs and photographs *unless their return is specifically requested*. This change in procedure, suggested by a number of providers, is expected to help contain unnecessary program costs.

Providers are instructed to clearly write “Do Not Recycle” on x-ray mailing envelopes when radiographs and photographs are to be returned. Use no other words or phrases, especially the word “Return” as the United States Postal Service interprets this to mean “Return to Sender” and sends the envelopes back to Denti-Cal.

Stickers are available for affixing to x-ray mailing envelopes. It is imperative that preimprinted or typed return address x-ray mailing envelopes be used. To request a supply of these stickers, please mark the box indicated on the Forms Reorder Request Form and mail or fax order to:

Shamrock Companies, Inc.
410 E. Grantline Rd.
Tracy, CA 95376
fax: 209/832/2105

If your office has a device such as a scanner that can transfer radiographs onto paper, Denti-Cal will accept the paper copy instead of the regular film. Paper copies of x-rays must be of good quality to be accepted. If the resolution of the paper image is inadequate, Denti-Cal will request the original film, which can delay processing. Be sure to indicate on the paper copy the date the x-ray was taken and which side of the mouth. Paper copies of x-rays will not be returned.

10. **OTHER ATTACHMENTS?** Check "yes" if additional documents are attached to the claim or TAR form. Other attachments include related correspondence, periodontal charts, operating room reports, or physician’s report describing the patient’s specific medical condition. If the physician’s report is concerning a homebound patient, be sure to document the reason the patient cannot leave the private residence and the length of time the patient will be homebound. Do not place attachments inside the x-ray envelope.

11. **ACCIDENT/INJURY? EMPLOYMENT RELATED?** Check "yes" if the patient was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the patient's accident or injury was "Employment Related" check "yes."

13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private or employer paid dental insurance carrier. You must bill the other insurance carrier prior to submitting the claim to Denti-Cal. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name, Social Security number and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits or denial letter. See Section 2 of this man-

ual for additional information on other coverage.

16. **CHDP - CHILD HEALTH AND DISABILITY PREVENTION?** Check "yes" if the treatment is related to a previous CHDP screening.

23. **POE (PROOF OF ELIGIBILITY) AREA:** This area is only used to record the new issue date for Benefits Identification Cards (BICs).

41. **DELETE:** If treatment was not performed, place an "X" in the column corresponding to the treatment not performed. Do NOT strike out the entire line.

29. **DATE SERVICE PERFORMED:** Indicate the date the service was performed. Use six (6) numerical digits, e.g., mm/dd/yy.

33. **TREATING MEDI-CAL PROVIDER NUMBER:** If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the treating provider number of the dentist or dental hygienist who performed the service. The treating provider number should be entered on the claim line for each service performed. The alpha character "D" should precede the number, e.g., D-2-3-4-5-6.

    A treating provider number is not needed for the following procedures: 045, 046, 047, 049, 050, 061, 062, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 125, 160, 955, 956 and 957.

    If there is only one dentist or dental hygienist treating patients at a service office, the field “Treating Medi-Cal Provider Number” does not need to be completed for any claim line.

44. **DATE PROSTHESIS ORDERED:** If an approved prosthesis cannot be placed, indicate the date the prosthesis was ordered from the dental laboratory.

45. **PROSTHESIS LINE FIELD:** Indicate the number of the line corresponding to procedure billed for the undelivered prosthesis.

34. **COMMENTS:** Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. It is helpful to note in this area if additional documentation is attached.

36. **PATIENT SHARE-OF-COST AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of the patient's share of cost collected by or due to your office from a recipient who has a share-of-cost obligation.

37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of "other coverage" payments the provider has received for the listed procedure. If either field 13 (OTHER DENTAL COVERAGE) or field 14 (MEDI-CARE DENTAL COVERAGE) is checked "yes," the amount received from the private dental insurance carrier or Medicare must be entered. The Explanation of Benefits (EOB) or denial letter from the private dental insurance carrier or Medicare must be attached to the claim for payment.

38. **DATE BILLED:** Enter the date the form is mailed using the six (6) numeric digit format, e.g., mm/dd/yy.

39. **SIGNATURE BLOCK:** The provider, or person authorized by the provider, must sign their own name in this signature box and date the form when requesting payment. Rubber stamp signatures are not acceptable.

    Additional services not requiring prior authorization may be added to the NOA. However, x-rays or documentation must be sent with the NOA to justify the additional services. After providing all necessary information on the form, please follow these steps:

    - Send the NOA marked "DENTI-CAL COPY" to Denti-Cal. Multi-page NOAs should be returned together.
    - Retain the form marked "DENTIST COPY" for your office records.
    - Sign and date the form marked “DENTI-CAL COPY.”
    - If x-rays are being submitted, enclose them in the green-bordered x-ray envelope and attach it to the NOA.
    - Mail completed forms in the large green-bordered envelopes that have been provided. Up to 10 forms can be mailed in a single envelope.

- Mail NOAs to the post office box listed below:

  Denti-Cal
  California Medi-Cal Dental Program
  P.O. Box 15610
  Sacramento, CA 95852-0610

To be considered for full payment (100 percent of the SMA amount), NOAs must be received by Denti-Cal not more than six months after the end of the month in which the final service is performed. NOAs that are received within nine months after the end of the month in which the final service was performed will be considered for payment at 75 percent of the SMA amount. NOAs that are received within one year after the end of the month in which the final service was performed will be considered for payment at 50 percent of the SMA amount. This billing limitation policy applies to each completed date of service.

Re-Evaluations

Only one request for re-evaluation per NOA is allowed and it must be received prior to the expiration date.

To request re-evaluation of a TAR, follow these steps:

1. Check the box marked "RE-EVALUATION IS REQUESTED" at the upper right corner of the NOA.
2. Do not sign the NOA.
3. Include documentation and enclose x-rays as necessary.
4. Return to:

   Denti-Cal
   California Medi-Cal Dental Program
   P.O. Box 15609
   Sacramento, CA 95852-0609

After the re-evaluation is made, a new NOA will be generated and sent to your office.

Extensions of Time

Extensions of time are no longer granted. Instead the time frame for approving Treatment Authorization Requests has changed from 120 to 180 days.

Outstanding Treatment Authorization Requests (TARs)

Since TARs can remain outstanding in the automated system for an extended length of time, Denti-Cal may deny authorization or payment of services based on Adjudication Reason Code 300A ("Procedure recently authorized to a different provider"). Denti-Cal may reconsider denial of authorization or payment of services that are duplicated on an outstanding TAR under the following circumstances:

- written notification from the patient stating that he or she will not be returning to the original provider's office;
- closure of the original provider's office;
- sale of the original provider's practice;
- death of the original provider;
- refusal of the original provider to return the Notice of Authorization;
- treatment (such as extraction) was provided on an emergency basis by one dentist when authorization for the same treatment was granted previously to a different dentist.

For reconsideration of denial of authorization or payment under these circumstances, please follow these guidelines:

1. Obtain a written statement from your patient that treatment will not be provided by the original dentist.
2. For an Explanation of Benefits (EOB) showing denial of payment: Attach your patient's statement to the EOB and follow the normal procedures for the Claim Inquiry Form.
3. For a NOA showing denial of treatment authorization: Attach your patient's statement and any other supporting documentation to the NOA, and submit the NOA with necessary x-rays to obtain reauthorization of the services. Denti-Cal will send to your office a new NOA showing the approved and allowed services and will void the original TAR. A new NOA will be sent to the original provider with the previously authorized procedures disallowed. Disallowed services will be indicated with Adjudication Reason Code

555 ("Authorization of this line is no longer valid") due to one of the following reasons:

a. Patient is/was being treated elsewhere;

b. Treatment was performed as an emergency;

c. A new claim/TAR is being processed.

Beneficiary Notification of TAR Status

Denti-Cal sends all Medi-Cal dental beneficiaries and/or their authorized representatives written notification when services on their treatment authorization requests (TARs) have been denied, modified or deferred. The notification indicates the status of the TAR and explains why the requested service was denied, modified or deferred. Beneficiaries do not receive written notification of approved TARs or services that have been performed.

When the dental office prepares a TAR for a beneficiary with an authorized representative who is not identified on the Medi-Cal card, the representative's name and address should be included in the "Comments" box (field 34) on page 2 of the Denti-Cal TAR form. This will assist Denti-Cal in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information.

Your patients may contact you for assistance with inquiries concerning their TARS. If you are unable to answer their questions, please refer your patients directly to Denti-Cal. A Denti-Cal patient or authorized representative may call the Beneficiary Services toll-free telephone number at (800) 322-6384 for assistance with inquiries about denied, modified or deferred TARs.

Figure 3-3a
NOTICE OF AUTHORIZATION: DENTI-CAL COPY

STAPLE HERE

DO NOT WRITE IN THIS AREA

STAPLE HERE

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

NOTICE OF AUTHORIZATION

03318100124

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 11/14/03
TO: 05/13/04

RE-EVALUATION IS REQUESTED ☐ YES

PAGE 1 OF 1

1. BENEFICIARY NAME (LAST, FIRST, M.I.)	2. BENEFICIARY SOC. SEC. NO.	3. SEX	4. BENEFICIARY BIRTHDATE	5. BENEFICIARY MEDI-CAL I.D. NO.
Last Name, First Name	999-99-9999	M x F	MO. mm DAY dd YR yyyy	

9. RADIOGRAPHS ATTACHED? CHECK IF YES / HOW MANY?	10. OTHER ATTACHMENTS? CHECK IF YES	11. ACCIDENT / INJURY? CHECK IF YES / EMPLOYMENT RELATED? YES	13. OTHER DENTAL COVERAGE? CHECK IF YES	16. CHDP YES	7. BENEFICIARY DENTAL RECORD NO.

Adams, James DDS Gxxxxx-01
30 Main Street xxx-xxx-xxxx
Anytown, CA xxxxx-xxxx

23.
BIC Issue Date: _____
EVC #: _____

41. DELETE	26. TOOTH NO. OR LETTER A-K-O-L	27. SUR-FACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. CODE	33. TREATING MEDI-CAL PROVIDER NO.
	19		1 Full Cast Crown		01	660	410.00	340.00		
	20		2 Full Cast Crown		01	660	410.00	340.00		
			3							
			4							
			5							
			6							
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			21							
			22							

DENTI-CAL
SAMPLE

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

* ADJUSTMENT CODES - SEE PROVIDER MANUAL
* AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO BENEFICIARY ELIGIBILITY.
* AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
* USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	820.00
46. TOTAL ALLOWANCE	680.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

NOTICE OF AUTHORIZATION
- FILL IN SHADED AREAS IF APPLICABLE
- SIGN AND RETURN FOR PAYMENT
- MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION

39. **TREATMENT COMPLETED - PAYMENT REQUESTED**
THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X _____ SIGNATURE _____ DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

SEND THIS PORTION TO DENTI-CAL • RETAIN "DENTIST COPY" FOR YOUR RECORDS

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

Figure 3-3b

NOTICE OF AUTHORIZATION: DENTIST COPY

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

NOTICE OF AUTHORIZATION

03318100124

AUTHORIZATION FOR SERVICE BELOW IS:

FROM: 11/14/03
TO: 05/13/04

RE-EVALUATION IS REQUESTED ☐ YES

PAGE 1 OF 1

1. BENEFICIARY NAME (LAST, FIRST, M.I.)	2. BENEFICIARY SOC. SEC. NO.	3. SEX	4. BENEFICIARY BIRTHDATE	5. BENEFICIARY MEDI-CAL I.D. NO.
Last Name, First Name	999-99-9999	M X F	MO. mm DAY dd YR yyyy	

9. RADIOGRAPHS ATTACHED? CHECK IF YES / HOW MANY?	10. OTHER ATTACHMENTS? CHECK IF YES	11. ACCIDENT / INJURY? EMPLOYMENT RELATED? CHECK IF YES	13. OTHER DENTAL COVERAGE? CHECK IF YES	16. CHDP YES	7. BENEFICIARY DENTAL RECORD NO.

Adams, James DDS Gxxxxx-01
30 Main Street xxx-xxx-xxxx
Anytown, CA xxxxx-xxxx

23. BIC Issue Date: _____

EVC #: _____

41. DELETE	26. TOOTH NO. OR LETTER A-M-O-I	27. SURFACES		28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	42. ALLOWANCE	43. ADJ. CODE	33. TREATING MEDI-CAL PROVIDER NO.
	19		1	Full Cast Crown		01	660	410.00	340.00		
	20		2	Full Cast Crown		01	660	410.00	340.00		
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			21								
			22								

DENTIST
Sample

44. DATE PROSTHESIS ORDERED

45. PROSTHESIS LINE ITEM

* ADJUSTMENT CODES - SEE PROVIDER MANUAL
* AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT SUBJECT TO BENEFICIARY ELIGIBILITY.
* AUTHORIZED ALLOWANCE MAY BE SUBJECT TO SHARE OF COST OR OTHER COVERAGE DEDUCTIONS.
* USE COLUMN 41 TO DELETE SERVICES AUTHORIZED BUT NOT PERFORMED.

35. TOTAL FEE CHARGED	820.00
46. TOTAL ALLOWANCE	680.00
36. BENEFICIARY SHARE-OF-COST AMOUNT	
37. OTHER COVERAGE AMOUNT	
38. DATE BILLED	

34. COMMENTS

NOTICE OF AUTHORIZATION

- FILL IN SHADED AREAS IF APPLICABLE
- SIGN AND RETURN "DENTI-CAL COPY" FOR PAYMENT
- RETAIN "DENTIST COPY" FOR YOUR RECORDS

DENTIST MUST SIGN "DENTI-CAL COPY"

SEND "DENTI-CAL COPY" TO DENTI-CAL • RETAIN THIS PORTION FOR YOUR RECORDS

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO BENEFICIARY'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.

The Resubmission Turnaround Document (RTD)

A Resubmission Turnaround Document (RTD) is a computer-generated form used by Denti-Cal to request missing or additional information on the claim, TAR, or NOA submitted by the provider.

The designation "TAR" is printed on all RTDs that originate from a Treatment Authorization Request. This is used by Denti-Cal to recognize any RTD that requires expeditious processing, due to origination from a TAR. "TAR" is printed in the "Correct Information" box in Part B of the RTD.

The top portion "A" lists the errors found on the original claim, TAR or NOA and the time limitation for response.

The bottom portion "B" is detachable and is to be completed by the provider and returned to Denti-Cal. Upon receipt of the RTD, Denti-Cal matches the RTD with the associated claim, TAR, or NOA, and the treatment form is then processed.

Part "A" notifies the provider of the specific information found in error on the claim, TAR, or NOA. Each error in Part "A" is assigned a letter of the alphabet under "field." Enter the "Correct Information" in Part "B" by matching the letter of the alphabet from Part "A" with the appropriate line and letter of the alphabet in Part "B."

If necessary, a multi-page RTD may be issued for an individual claim, TAR, or NOA. Be sure to return all pages of the RTD in one envelope.

If the RTD is not returned to Denti-Cal within the 45-day time limitation, the claim, TAR, or NOA will be denied according to Denti-Cal policies.

How to Complete the RTD

PART "A" - TOP PORTION: Computer-generated by Denti-Cal; retained by the provider.

The appropriate box (Claim, TAR or NOA) will be checked to indicate the type of document submitted.

NOTE: Please read instructions carefully.

1. **BILLING PROVIDER NAME AND MEDI-CAL PROVIDER NUMBER:** As it appears on the document submitted by your office.
2. **MAILING ADDRESS**: As it appears on the document submitted.
3. **CITY, STATE, ZIP CODE:** As it appears on the document submitted.
4. **PAGE __OF__ PAGES:** A multi-page RTD may be issued for an individual claim, TAR, or NOA. Be sure to return all pages of the RTD in one envelope.
5. **RTD ISSUE DATE:** The date the RTD was issued.
6. **RTD DUE DATE:** The date the response is due at Denti-Cal.
7. **PATIENT NAME:** As it appears on the document submitted.
8. **PATIENT MEDI-CAL I.D. NUMBER:** As it appears on the document submitted.
9. **PATIENT DENTAL RECORD NUMBER:** As it appears on the document submitted.
10. **BEGINNING DATE OF SERVICE:** As it appears on the document submitted.
11. **AMOUNT BILLED:** As it appears on the document submitted.
12. **DOCUMENT CONTROL NO.:** The DCN assigned to the document submitted.
13. **ITEM:** The letter of the alphabet assigned by the computer to identify the line in Part "B" where the "Correct Information" should be entered.
14. **INFORMATION BLOCK:** This will indicate the exact name of the field in question on the claim, TAR, or NOA.
15. **CLAIM FIELD NO.:** Indicates number corresponding to the information block on the claim, TAR, or NOA.
16. **CLAIM LINE:** The line number on the claim, TAR or NOA.
17. **SUBMITTED INFORMATION:** The description of the incorrect information submitted by your office.
18. **PROCEDURE CODE:** Procedure codes as reported on the claim, TAR or NOA.
19. **ERROR CODE:** A code identifying the error that has been made on the claim, TAR or NOA.
20. **ERROR DESCRIPTION:** A description of the error that has been made on the claim, TAR or NOA.

Part “B” – Bottom Portion: Complete and return to Denti-Cal.

The following information is printed by Denti-Cal on the RTD:

a. Billing provider name
b. Medi-Cal Provider Number
c. Patient Name
d. Patient Medi-Cal Identification Number
e. Document Control Number (DCN)
f. Claim Type
g. Page _of_
h. Submitted Information
i. Claim Field Number
j. Claim Line
k. Error Code
l. Item

1. **CORRECT INFORMATION:** The provider enters the correct information on the appropriate line in Part "B" corresponding to the information found in error in Part "A."
2. **SIGNATURE/DATE BLOCK:** The provider, or person authorized by the provider, must sign and date the form prior to its return. Lack of signature will result in disallowance of the document. Rubber stamp signatures are not acceptable.
3. **POE/COMMENTS BLOCK:** This area may be used for any comments.

   Return the completed RTD to:

   Denti-Cal
   California Medi-Cal Dental Program
   P.O. Box 15609
   Sacramento, CA 95852-0609

Figure 3-4

RESUBMISSION TURNAROUND DOCUMENT

☐ CLAIM ☒ TAR ☐ NOA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

IMPORTANT: LISTED IN SECTION "A" ARE ERROR(S) FOUND ON THE CLAIM/TAR/NOA. TO FACILITATE PROCESSING, TYPE OR PRINT THE CORRECT INFORMATION IN THE CORRESPONDING ITEM IN SECTION "B". SIGN AND DATE FORM AND RETURN SECTION "B" (BOTTOM PORTION) TO DENTI-CAL. PLEASE RESPOND PROMPTLY, AS PROCESSING CANNOT BE ACCOMPLISHED UNLESS CORRECTIONS ARE RECEIVED BY THE DUE DATE INDICATED. FAILURE TO RESPOND WITHIN THE TIME LIMITATION WILL RESULT IN DENIAL OF SERVICES. IF YOU HAVE ANY QUESTIONS CALL 800-423-0507 FOR ASSISTANCE OR REFER TO YOUR PROVIDER MANUAL FOR FURTHER EXPLANATION.

BILLING PROVIDER NAME, MAILING ADDRESS, CITY, STATE, ZIP CODE	MEDI-CAL PROVIDER NO.	NOTICE	PAGE	OF	PAGES
Adams, James DDS 30 Main Street Anytown, CA xxxxx-xxxx	Gxxxxx-01		1		1

RTD ISSUE DATE	RTD DUE DATE

PATIENT NAME	PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NO.	BEGINNING DATE OF SERVICE	AMOUNT BILLED	DOCUMENT CONTROL NO.
Last Name, First Name	xxxxxxxxxx			662.00	01297102350

ITEM	INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION
A		26	4		201	5	Procedure requires tooth code

Sample

RETAIN THIS PORTION
DETACH ALONG THIS PERFORATION

DOCUMENT CONTROL NUMBER • FOR DENTI-CAL USE ONLY

DENTI-CAL USE ONLY

DCN	CLAIM TYPE	PAGE	OF	PAGES
01297102350	T	01		01

BILLING PROVIDER NAME: Adams, James DDS

MEDI-CAL PROVIDER NUMBER: Gxxxxx-01

PATIENT NAME: Last Name, First Name

PATIENT MEDI-CAL I.D. NUMBER: xxxxxxxxxx

This is to certify that the corrected information is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

X *Mary Smith* SIGNATURE *11/12/01* DATE

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

IF REQUESTED AFFIX P.O.E. LABEL(S) IN THIS SPACE. THIS SPACE MAY BE USED FOR COMMENTS.

SUBMITTED INFORMATION	CLAIM FIELD NO.	CLAIM LINE	ERROR CODE	CORRECT INFORMATION
	26	04	51	A Tooth # 14

CORRECTED INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A".

B

RETURN THIS PORTION TO: **DENTI-CAL** P.O. BOX 15609, SACRAMENTO, CA 95852-0609

THIS PAGE INTENTIONALLY LEFT BLANK

Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a computer-generated statement which accompanies each check sent to Denti-Cal providers. It lists all paid and denied claims that have been adjudicated or adjusted during the payment cycle, as well as non-claims specific information. Claims and TARs that have been in process over 18 days are also listed.

Lost/Misplaced EOBs

Providers are issued an EOB each week which lists, in detail, all activity on documents for accounting and tracking purposes. Listed on the weekly EOB are all paid claims, adjustments and current status of pending documents. In addition, the EOB contains seminar information, accounts payable and receivable activity, and notification of direct deposit information.

Each service office with claim activity receives an EOB which should be used for payment posting, account balancing, and monitoring the progress of documents in process as they go through the system. Service offices managed through corporate offices should have internal procedures in place to ensure they receive the most current information relative to their submissions, i.e., FAX, scanned e-mail, etc.

Lost or misplaced EOBs can be reprinted at a cost of ten cents ($.10) per page. For multiple EOB requests requiring research and restoration there is an additional cost for labor of ten dollars ($10.00) per hour. Please submit your request ***in writing***, including your provider number and the EOB issue date to:

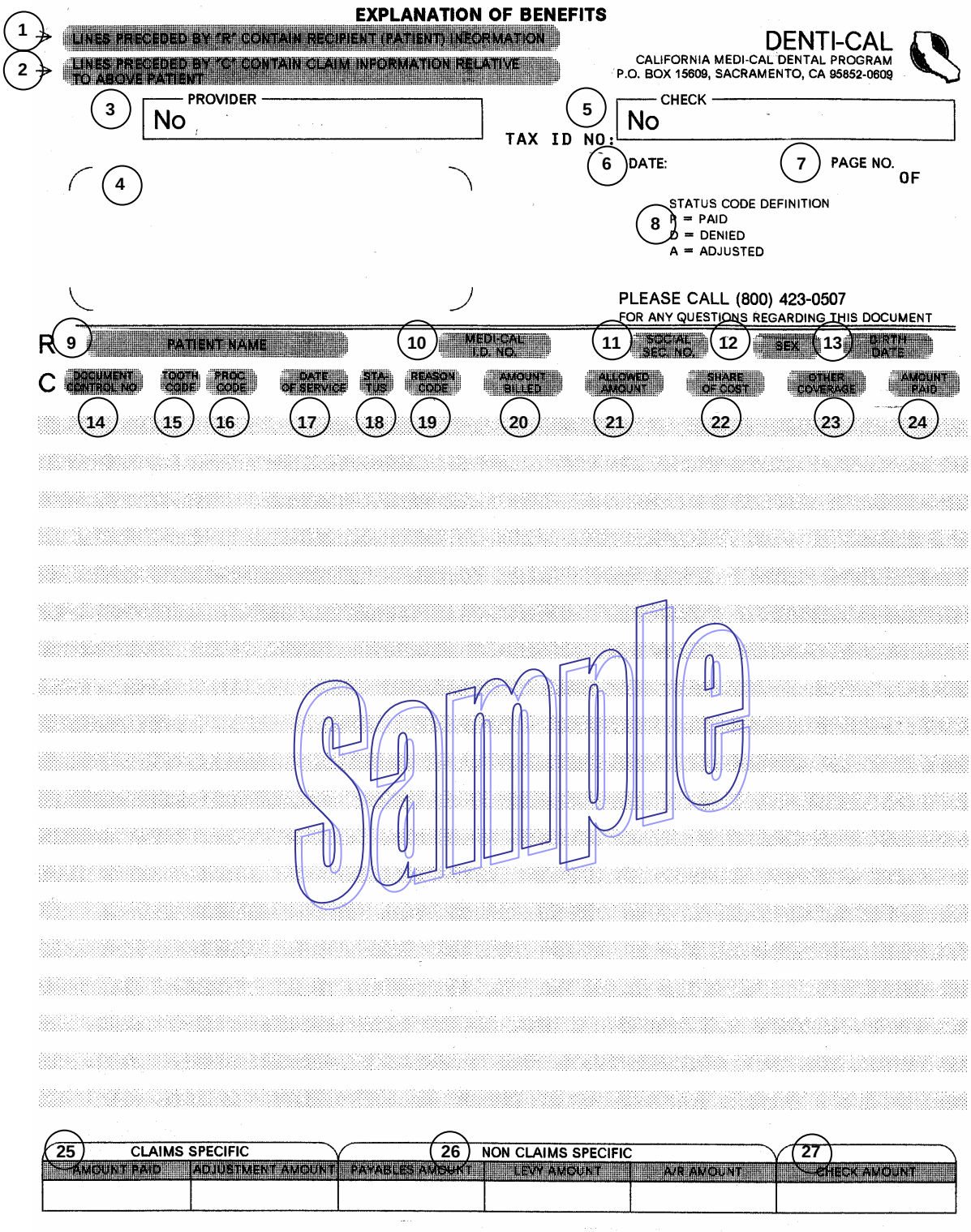
Provider Services General Correspondence
P.O. Box 15609
Sacramento, CA 95852-0609

How to Read the EOB

Following is an explanation of each item shown on the sample EOB in Figure 3-5. Each item is numbered to correspond with those numbers on the sample EOB found on the next page.

1. **Reference lines preceded by an "R"** contain recipient or patient information.
2. **Reference lines preceded by a "C"** which contain claim information for the listed patient.
3. **PROVIDER NO.:** The provider's Medi-Cal Identification Number.
4. **PROVIDER'S NAME AND ADDRESS:** The provider's name and billing address.
5. **CHECK NO.:** Number of the check issued with the EOB.
6. **DATE:** Date EOB was issued.
7. **PAGE NO.:** Page number of the EOB.
8. **STATUS CODE DEFINITION:** The status code used to identify each claim line. "P" = Paid, "D" = Denied, "A" = Adjusted.
9. **PATIENT NAME:** Each recipient (patient) is listed once per category.
10. **MEDI-CAL I.D. NO.:** The recipient's Medi-Cal identification number.
11. **SOCIAL SEC NO.:** The recipient's Social Security number.
12. **SEX:** The sex code for each recipient, "M" = male, "F" = female.
13. **BIRTHDATE:** Birthdate of each recipient.
14. **DOCUMENT CONTROL NUMBER (DCN):** The number assigned to each claim by Denti-Cal.
15. **TOOTH CODE:** Lists the tooth number, letter, arch or quadrant on which the procedure was performed.
16. **PROC. CODE:** The code listed on a claim line that identifies the procedure performed. This code may be different from the procedure code submitted on the claim or TAR because the procedure code may have been modified by a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim.
17. **DATE OF SERVICE:** The date the service was performed.
18. **STATUS:** Identifies the status of each claim line. The status codes are explained in Section 5, "EOB 'Claims In Process' Reason Codes."
19. **REASON CODE:** The code explains why a claim was either paid at an amount other than billed; changed; altered during processing; or denied. The reason codes and a written explanation of each one are printed on the EOB.
20. **AMOUNT BILLED:** The amount billed for each claim line.
21. **ALLOWED AMOUNT:** The amount allowed for each claim line; this amount is the lesser of the billed amount or the amount allowed by the Schedule of Maximum Allowances.
22. **SHARE-OF-COST:** The amount the patient paid towards a share-of-cost obligation.
23. **OTHER COVERAGE:** The amount paid by another carrier or by Medicare.
24. **AMOUNT PAID:** The total amount paid to a provider after deductions, if applicable, as shown in numbers 22 and 23.
25. **CLAIMS SPECIFIC:** Only printed on the last page of the EOB. These amounts are the totals for all adjudicated claim lines listed on the EOB.
26. **NON-CLAIMS SPECIFIC:** The (a) payables amount; (b) levy amounts, (c) accounts receivable amounts. Only printed on the last page of the EOB.
27. **CHECK AMOUNT:** The amount of the check that accompanies this EOB.

Figure 3-5


EXPLANATION OF BENEFITS
1
LINES PRECEDED BY 'R' CONTAIN RECIPIENT (PATIENT) INFORMATION
2
LINES PRECEDED BY 'C' CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE PATIENT
DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609
3
PROVIDER
No
5
CHECK
No
TAX ID NO:
6
DATE:
7
PAGE NO.
OF
4
8
STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED
PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT
R
9
PATIENT NAME
10
MEDI-CAL I.D. NO.
11
SOCIAL SEC. NO.
12
SEX
13
BIRTH DATE
C
DOCUMENT CONTROL NO
TOOTH CODE
PROC CODE
DATE OF SERVICE
STA TUS
REASON CODE
AMOUNT BILLED
ALLOWED AMOUNT
SHARE OF COST
OTHER COVERAGE
AMOUNT PAID
14
15
16
17
18
19
20
21
22
23
24
Sample
25
CLAIMS SPECIFIC
AMOUNT PAID
ADJUSTMENT AMOUNT
26
NON CLAIMS SPECIFIC
PAYABLES AMOUNT
LEVY AMOUNT
A/R AMOUNT
27
CHECK AMOUNT

Example No. 1:
Paid Claim with Levy Deduction

1.-11. This information, printed on each page of the EOB, is explained on a preceding page entitled “How to Read the EOB.”

12. **LEVIES (AMOUNTS WE PAID FOR YOU):** When an EOB reflects a levy deduction, the levy amount is shown with the following information:

    Check Number - The number of the check issued to the levy holder by Denti-Cal.

    Holder Number - The number issued by Denti-Cal to the levy holder upon receipt of a levy request.

    Name of Levy Holder - The name of the levy holder, e.g., the Internal Revenue Service.

    Amount - The amount of the payment issued to the levy holder by Denti-Cal, shown as a negative amount. The levy amount shown in Example 1 is deducted from the check issued to the provider referenced on this EOB.

13. **CLAIMS SPECIFIC:** Lists the totals for all adjudicated claim lines listed on Example 1.

14. **NON CLAIMS SPECIFIC:** This area on Example 1 shows the levy amount ($100.00) deducted from the amount of the check issued to the provider which corresponds to this EOB.

15. **CHECK AMOUNT:** The amount shown for this check ($55.00) reflects the Claims Specific Amounts paid listed in field 13 ($155.00) minus the Non Claims Specific Levy Amount Shown in field 14 ($100.00).

Figure 3-6
Example 1: Paid Claim, Levy Deduction

EXPLANATION OF BENEFITS

→ LINES PRECEDED BY "R" CONTAIN RECIPIENT (PATIENT) INFORMATION
→ LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE PATIENT

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER
No Gxxxxx-01

CHECK
No xxxxxxxx

TAX ID NO: xxxxxxxxx

DATE: mm/dd/yy

PAGE NO. x OF x

Adams, James
30 Main Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

	PATIENT NAME	MEDI-CAL I.D. NO.	SOCIAL SEC. NO.	SEX	BIRTH DATE
R					

	DOCUMENT CONTROL NO	TOOTH CODE	PROC CODE	DATE OF SERVICE	STATUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID
C											

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.

(12) LEVIES (AMOUNTS WE PAID FOR YOU)

CHECK-NO	HOLDER-NO	NAME OF LEVY HOLDER	AMOUNT
400012908	000000132	LEVY HOLDER	-100.00
		* TOTAL LEVIES	-100.00 *

Sample

(13) CLAIMS SPECIFIC		(14) NON CLAIMS SPECIFIC			(15)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
155.00	.00	.00	100.00	.00	55.00

Example No. 2: Levy Payment

This is an example of an EOB that would accompany a levy payment to a levy holder, e.g., the Internal Revenue Service, made by Denti-Cal on behalf of the provider.

1. **LEVY NBR:** The number issued by Denti-Cal that identifies the levy.
2. **ACCOUNT OF:** The name of the provider for whom the levy payment is being made.
3. **SSN/TAX ID:** The Social Security number or Tax Identification Number of the provider for whom the levy payment is being made.
4. **CHECK NO.**: The number of the check, issued to the provider, from which the levy payment is deducted. The provider's EOB will identify the number of the check issued to the levy holder, the levy number, the name of the levy holder, and the amount of the levy payment issued.
5. **AMOUNT OF PAYMENT:** Shows the amount of the payment to the levy holder.
6. **CHECK AMOUNT:** The amount of the check sent by Denti-Cal to the levy holder.

Figure 3-7
Example 2: Levy Payment

EXPLANATION OF BENEFITS

→ LINES PRECEDED BY "R" CONTAIN RECIPIENT (PATIENT) INFORMATION
→ LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE PATIENT

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER
No Gxxxxx-01

TAX ID NO: xxxxxxxxx

CHECK
No xxxxxxxx

DATE: mm/dd/yy

PAGE NO. x OF x

Levy Holder
7777 Any Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

R	PATIENT NAME			MEDI-CAL I.D. NO.		SOCIAL SEC. NO.	SEX	BIRTH DATE				
C	DOCUMENT CONTROL NO	TOOTH CODE	PROC CODE	DATE OF SERVICE	STA TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID	

THE ENCLOSED CHECK IS IN PAYMENT ON THE FOLLOWING LEVY HELD BY YOU:

(1) LEVY NBR	(2) ACCOUNT OF	(3) SSN/TAX-ID	(4) CHECK NO.
000000083	James Adams	xxx-xx-xxxx	010300764

(5) AMOUNT OF PAYMENT
50.00

Sample

(6)

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
					50.00

Example No. 3: Documents In Process

The "Documents in Process" section printed on the EOB will list information on all in-process documents grouped together by type of document (C = Claim, N = NOA, T = TAR, and R = TAR Re-evaluation) and in-process status (professional review, state review, information required, etc).

1-8. **DOCUMENTS-IN-PROCESS**: Information listed in these areas of Example No. 3 is a description of each document that has been "in process" for 18 days or longer.

9. **CODE**: The appropriate code listed indicates the reason that the claim is "in process."

10. **TOTAL CLAIMS IN PROCESS**: The example shows the total number of documents “in process.”

11. **TOTAL BILLED**: Total billed amounts for the documents “in process.”

12. The last page of the EOB containing in-process documents information provides a legend listing the reason codes for documents in process. Beside each code is a printed explanation which defines the reason a particular document is "in process."

13. Denti-Cal will notify you of upcoming provider training seminars with a message appearing at the end of your Explanation of Benefits (EOB) statement. The location of the training seminar(s) nearest your office is determined automatically and will be printed on your EOB.

14. The location of the training seminar(s) nearest your office is determined automatically and will be printed on your EOB.

Figure 3-8
Example 3: Claims/TARs in Process

EXPLANATION OF BENEFITS

→ LINES PRECEDED BY "R" CONTAIN RECIPIENT (PATIENT) INFORMATION
→ LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE PATIENT

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER
No Gxxxxx-01

TAX ID NO: xxxxxxxxx

CHECK
No xxxxxxxx

DATE: mm/dd/yy

PAGE NO. x OF x

Adams, James
30 Main Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

R PATIENT NAME | MEDI-CAL I.D. NO. | SOCIAL SEC. NO. | SEX | BIRTH DATE

C DOCUMENT CONTROL NO | TOOTH CODE | PROC CODE | DATE OF SERVICE | STATUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

DOCUMENTS IN-PROCESS

LAST NAME	FIRST NAME	MEDI-CAL ID	SSAN	DOB	DCN	AMOUNT BILLED	*CODE	
Last Name	First Name	9999999999		mm/dd/yyyy	012345678901	60.00	C	IR
Last Name	First Name	9999999999		mm/dd/yyyy	12345678912	3200.00	C	DV
Last Name	First Name	9999999999		mm/dd/yyyy	23456789123	3200.00	C	DV

TOTAL DOCUMENTS IN-PROCESS 3 TOTAL BILLED 6460.00

ADJUSTMENT CLAIM

(1) DOCUMENTS IN-PROCESS

(2) LAST NAME	(3) FIRST NAME	(4) MEDI-CAL ID	(5) SSAN	(6) DOB	(7) DCN	(8) AMOUNT PAID	(9) CODE
Last Name	First Name	9999999999	999-99-9999	mm/dd/yyyy	34567891234	.00	DV
Last Name	First Name	9999999999	999-99-9999				

(10) TOTAL ADUSTMENT CLAIMS IN-PROCESS (11) TOTAL BILLED

*(12) THE FOLLOWING LEGEND HAS BEEN INCLUDED FOR IN-PROCESS STATUS CODES

C = CLAIM N = NOA T = TAR R = TAR RE-EVALUATION

DV - DATA VALIDATION (DOCUMENT IS AWAITING REVIEW OF KEYED DATA AGAINST DOCUMENT INFORMATION)
IR - INFORMATION REQUIRED (DOCUMENT REQUIRES MORE DATA FROM THE BILLING PROVIDER. AN RTD HAS BEEN SENT TO THE BILLING PROVIDER)
RV - RECIPIENT VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF RECIPIENT INFO)
PV - PROVIDER VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF PROVIDER INFO)
PR - PROFESSIONAL REVIEW (DOCUMENT IS SCHEDULED FOR PROFESSIONAL REVIEW)
RS - CLINICAL SCREENING (DOCUMENT IS SCHEDULED FOR CLINICAL SCREENING REVIEW)
SR - STATE REVIEW (DOCUMENT IS SCHEDULED FOR REVIEW BY STATE STAFF)

(13) THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN ON 9/10/03 FROM 9:00 A.M. TO 12:00 P.M. PLEASE CALL (800) 423-0507 FOR RESERVATIONS.

(14) THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN ON 9/11/03 FROM 8:00 A.M. TO 12:00 P.M. PLEASE CALL (800) 423-0507 FOR RESERVATIONS.

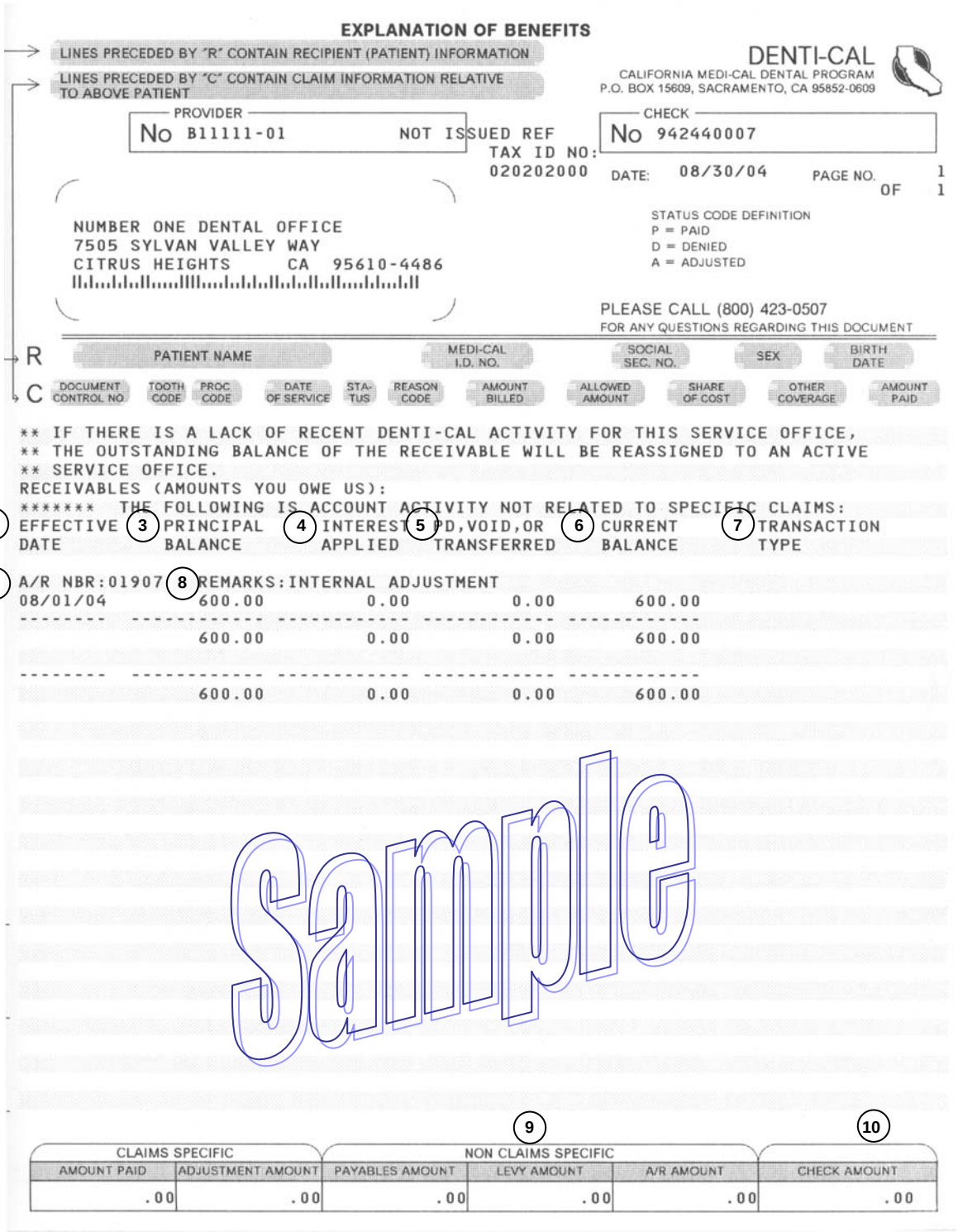
CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT

Sample

Example No. 4: Accounts Receivable (AR)

1. **A/R NBR:** The number assigned by Delta Dental that identifies the accounts receivable (the amount the provider owes to Delta).
2. **EFFECTIVE DATE:** The date the accounts receivable was created.
3. **PRINCIPAL BALANCE:** The amount of the accounts receivable when it was created.
4. **INTEREST APPLIED:** If applicable, is the amount of interest applied to the outstanding A/R. Always factored in, it is now recorded
5. **PD, VOID, OR TRANSFERRED:** The amount the provider has paid or that has been deducted from the provider's check towards the accounts receivable.
6. **CURRENT BALANCE:** The current amount the provider owes on the accounts receivable.
7. **TRANSACTION TYPE:** If applicable, this reflects the type of payment transaction(s).
8. **REMARKS:** This area provides an explanation for the accounts receivable. In this example, Delta issued an overpayment to the provider for a document with DCN 98104100330.
9. **NON CLAIMS SPECIFIC A/R AMOUNT:** The total of the accounts receivable listed on the EOB or the amounts owed by the provider.
10. **CHECK AMOUNT:** The final amount of the check issued to the provider that corresponds to this EOB.

Figure 3-9
Example 4: Accounts Receivable



EXPLANATION OF BENEFITS

LINES PRECEDED BY "R" CONTAIN RECIPIENT (PATIENT) INFORMATION

LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE PATIENT

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER
No B11111-01 NOT ISSUED REF

CHECK
No 942440007

TAX ID NO: 020202000

DATE: 08/30/04 PAGE NO. 1 OF 1

NUMBER ONE DENTAL OFFICE
7505 SYLVAN VALLEY WAY
CITRUS HEIGHTS CA 95610-4486

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

R PATIENT NAME | MEDI-CAL I.D. NO. | SOCIAL SEC. NO. | SEX | BIRTH DATE

C DOCUMENT CONTROL NO. | TOOTH CODE | PROC CODE | DATE OF SERVICE | STA-TUS | REASON CODE | AMOUNT BILLED | ALLOWED AMOUNT | SHARE OF COST | OTHER COVERAGE | AMOUNT PAID

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE,
** THE OUTSTANDING BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE
** SERVICE OFFICE.
RECEIVABLES (AMOUNTS YOU OWE US):
******* THE FOLLOWING IS ACCOUNT ACTIVITY NOT RELATED TO SPECIFIC CLAIMS:

(2) EFFECTIVE DATE	(3) PRINCIPAL BALANCE	(4) INTEREST APPLIED	(5) PD,VOID,OR TRANSFERRED	(6) CURRENT BALANCE	(7) TRANSACTION TYPE
(1) A/R NBR:01907	(8) REMARKS:INTERNAL ADJUSTMENT				
08/01/04	600.00	0.00	0.00	600.00	
	600.00	0.00	0.00	600.00	
	600.00	0.00	0.00	600.00	

Sample

CLAIMS SPECIFIC		(9) NON CLAIMS SPECIFIC			(10)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
.00	.00	.00	.00	.00	.00

Example No. 5: Accounts Payable (AP)

1. **PAYABLE NUMBER:** The number assigned by Delta Dental that identifies the accounts payable (the amounts Delta owes the provider).
2. **REASON CODE:** The code that identifies the reason for the payable. See Section 5 for the AR/AP Reason Codes and Descriptions.
3. **DESCRIPTION:** An explanation of the transaction.
4. **CHECK #:** The number of the check that the provider sent to Delta.
5. **AMOUNT:** Lists the dollar amount of each payable listed on the EOB.
6. **TOTAL PAYABLES:** The total amount of payables listed on the EOB.
7. **TOTAL OF CHECK NUMBER:** The amount of the check the provider sent to Delta.
8. **NON CLAIMS SPECIFIC PAYABLES AMOUNT:** The total amount of the provider accounts payable shown on this EOB.
9. **CHECK AMOUNT:** The final amount of the check issued to the provider that corresponds to this EOB.

Figure 3-10
Example 5: Accounts Payable

EXPLANATION OF BENEFITS

→ LINES PRECEDED BY "R" CONTAIN RECIPIENT (PATIENT) INFORMATION
→ LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE PATIENT

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER
No Gxxxxx-01

CHECK
No xxxxxxxx

TAX ID NO: xxxxxxxxx
DATE: mm/dd/yy
PAGE NO. x OF x

Adams, James
30 Main Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

R	PATIENT NAME			MEDI-CAL I.D. NO.		SOCIAL SEC. NO.	SEX	BIRTH DATE				
C	DOCUMENT CONTROL NO	TOOTH CODE	PROC CODE	DATE OF SERVICE	STATUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID	

** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING
** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.
RECEIVABLES (AMOUNTS YOU OWE US):

****** THE FOLLOWING IS ACCOUNT ACTIVITY NOT RELATED TO SPECIFIC CLAIMS:

PAYABLES/CASH RECEIPTS (AMOUNTS OWE TO YOU/PAID BY YOU)

(1) PAYABLE NUMBER	(2) REASON CODE	(3) DESCRIPTION	(5) AMOUNT
0000435	5	PAYABLE	$50.00
0000436	5	(4) CHECK # 123456 APPLIED TO ACCOUNT	50.00
		* TOTAL PAYABLES (6)	

(7) TOTAL OF CHECK NUMBER 000123456 $50.00

Sample

CLAIMS SPECIFIC		(8) NON CLAIMS SPECIFIC			(9)
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
.00	.00	100.00	.00	.00	100.00

Example No. 6: Readjudicated Claim

The original claim is described in part A of Example No. 6. Part B is a description of the results of the readjudication of the previously processed claim. The areas on the sample EOB that distinguishes the original claim information from the readjudicated claim information is as follows:

PART "A" – ORIGINAL CLAIM INFORMATION

1. **The status code "A"** indicates this claim service line on the original claim was allowed.
2. **The amount that was allowed** for this claim service line when the claim service line was originally processed.
3. **The amount of the payment that was made** to the provider for this claim service line when the claim was originally processed by Denti-Cal.

PART "B" – READJUDICATED CLAIM INFORMATION

4. **The code and description** indicate why the claim was readjudicated. Descriptions of Readjudication Codes and Messages (Claim Correction Codes) can be found in Section 5 of this manual.
5. **The status code "P"** indicates the claim service line was "paid" after readjudication.
6. **This amount ($9.35)** shows the amount allowed for this claim service line after readjudication.
7. **The amount listed** is the total amount paid to the provider for the readjudicated claim service line.
8. **Total adjusted claims:** This line shows the amounts allowed and to be paid to the provider after the claim was readjudicated.

Figure 3-11
Example Number 6: Readjudicated Claim

EXPLANATION OF BENEFITS

→ LINES PRECEDED BY "R" CONTAIN RECIPIENT (PATIENT) INFORMATION
→ LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE PATIENT

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609, SACRAMENTO, CA 95852-0609

PROVIDER
No Gxxxxx-01

CHECK
No xxxxxxxx

TAX ID NO: xxxxxxxxx
DATE: mm/dd/yy
PAGE NO. x OF x

Adams, James
30 Main Street
Anytown, CA xxxxx-xxxx

STATUS CODE DEFINITION
P = PAID
D = DENIED
A = ADJUSTED

PLEASE CALL (800) 423-0507
FOR ANY QUESTIONS REGARDING THIS DOCUMENT

	PATIENT NAME	MEDI-CAL I.D. NO.	BLOCK/ SECTION	SEX	BIRTH DATE
R					

	DOCUMENT CONTROL NO	TOOTH CODE	PROC CODE	DATE OF SERVICE	STA TUS	REASON CODE	AMOUNT BILLED	ALLOWED AMOUNT	SHARE OF COST	OTHER COVERAGE	AMOUNT PAID
C											

Sample

ADJUDICATED CLAIMS

R	Last Name	First Name			9999999999	999-99-9999		M		mm/dd/yyyy
C	9613667891	558	05/16/96	P	75.00	37.50				37.50
	CLAIM TOTAL				75.00	37.50				37.50
	** TOTAL ADJUDICATED CLAIMS				75.00	37.50				37.50

ADJUSTMENT CLAIMS

A

R	Last Name	First Name	9999999999			999-99-9999		M			mm/dd/yyyy
C	96137789123	551	05/17/96	A	(1) 318	-55.00	.00	(2)		(3)	.00
	CLAIM TOTAL					-55.00	.00				.00

B

R	Last Name	First Name	9999999999		999-99-9999		M				mm/dd/yyyy
(4)	C#30 : NEW OR ADDITIONAL DOCUMENTATION SUBMITTED										
C	96137789123	551	05/17/96	P	(5)	55.00	9.35	(6)		(7)	9.35
	CLAIM TOTAL					55.00	9.35				9.35
(8)	* TOTAL ADJUSTED CLAIMS					.00	9.35				9.35
	** PROVIDER CLAIMS TOTAL					75.00	46.85				46.85

*** CLAIMS WITH INCONSISTENT PROCEDURE CODE FORMATS HAVE BEEN
*** CONVERTED TO A COMPATIBLE FORMAT (3, 4 OR 5-DIGIT) BASED ON
*** THE FORMAT USED FOR THE FIRST CLAIM SERVICE LINE ON EACH CLAIM

CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT
37.50	9.35	.00	.00	.00	46.85

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The Claim Inquiry Form (CIF)

The Claim Inquiry Form (CIF) is used by the provider to inquire about the status of a claim or TAR or to request re-evaluation of a modified or denied claim. Any other type of inquiry or request, e.g., check inquiries, should be handled through correspondence. Only originals of these forms will be accepted and processed by Denti-Cal. Before sending a CIF, please call Denti-Cal at (800) 423-0507. We may be able to answer your inquiry immediately.

For your convenience, CIFs may be obtained, free of charge, from the Denti-Cal forms supplier. Please mail or fax your order using the information found below:

Shamrock Companies, Inc.
410 E. Grantline Rd
Tracy, CA 95376
fax: (209) 832-2105

CIF Time Limitations Claim/TAR Status

Providers may submit claims for full payment (100 percent of the SMA amount) no later than six months after the end of the month in which services were performed. Claims received six to nine months after the end of the month in which the services were performed will be considered for payment at 75 percent of the SMA amount. Claims received ten to twelve months after the end of the month in which the services were performed will be considered for payment at 50 percent of the SMA amount. Claims received more than twelve months after the end of the month in which the services were performed will not be considered for payment.

If the status of a claim or TAR does not appear on the Explanation of Benefits in the "Documents-In-Process" section within one month after the claim was submitted, you should complete a CIF and send it to Denti-Cal.

Claim Re-Evaluations

The dental office should wait until the status of a processed claim appears on the Explanation of Benefits (EOB) before submitting a Claim Inquiry Form (CIF) for re-evaluation. The EOB will give the reason the claim was modified or disallowed. A response to the re-evaluation request will appear on the Explanation of Benefits (EOB) in the "Adjusted Claims" section.

Denti-Cal must receive the inquiry within six calendar months of the date of the EOB. Be sure to submit a copy of the disallowed or modified claim plus any additional x-rays or documentation pertinent to the procedure under reconsideration.

How to Complete the CIF

Use one CIF for one claim or TAR inquiry. Please print or type all information:

1. **BILLING PROVIDER NAME:** Enter the billing provider's name in either the “doing business as” format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.
2. **BILLING PROVIDER NUMBER:** Enter the billing provider's Medi-Cal Provider Number. NOTE: The Medi-Cal Provider Number must be present and correct on all forms.
3. **BILLING PROVIDER ADDRESS AND TELEPHONE NUMBER:** Enter the service office address where treatment is rendered. A service office address should be a street address, including city, state and zip code. A post office box cannot be used as a service office; however, it is acceptable in rural areas only to use a route number with a post office box number.

   If the service office address is different from the address where you receive payment, please be sure to notify Denti-Cal so payment can be directed to the appropriate location.

   It is important to include the telephone number of the service office, including area code, so Denti-Cal can contact you in case any questions arise while processing your document.

   Please Note: It is important that the billing provider’s name, Medi-Cal billing number, address and telephone number are accurate and match the information Denti-Cal has recorded on its system. Claim and TAR forms that are pre-printed with the provider's name/number/address are available at no charge from the Denti-Cal forms supplier. Please check this information for accuracy on all pre-printed supplies. If you are using forms printed from your office computer, please be sure the computer is programmed with the correct provider information.
4. **CITY, STATE, ZIP CODE:** Enter the city, state, and zip code where the service office is located.
5. **PATIENT NAME:** Enter the patient's last name, first name, and middle initial.
6. **DOCUMENT CONTROL NUMBER (CLAIM RE-EVALUATION ONLY):** Enter the Document Control Number of the document in question. If you are inquiring about multiple claims or TARs, be sure to submit one CIF only for each document in question.
7. **PATIENT MEDI-CAL ID NUMBER:** Enter the patient's 10-digit State Recipient Identification Number.
8. **PATIENT RECORD NUMBER:** If you assign a Dental Record Number or Account Number to a patient, enter the assigned number that will be referenced on any subsequent correspondence from Denti-Cal.
9. **DATE BILLED:** Enter the date the claim or the TAR was originally mailed to Denti-Cal.
10. **INQUIRY REASON - CHECK ONLY ONE BOX:** Indicate if this inquiry is seeking the status of a claim or TAR ("tracer") or is requesting a re-evaluation of a claim.
11. **REMARKS:** Use this area to provide any additional information needed to justify the inquiry being made. Include x-rays if appropriate and a copy of the claim and the TAR in question.
12. **SIGNATURE:** The provider, or person authorized by the provider, must sign and date the form. Rubber stamp signatures are not acceptable.

    Mail the form to:

    Denti-Cal
    California Medi-Cal Dental Program
    P.O. Box 15609
    Sacramento, CA 95852-0609

Figure 3-12a
CLAIM INQUIRY FORM
(Claim/TAR Status Only)

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (E.O.B.)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your provider manual for detailed instructions
- For clarification call DENTI-CAL

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

BILLING PROVIDER NAME	MEDI-CAL PROVIDER NUMBER
Adams, James	Gxxxxx-01
MAILING ADDRESS	**TELEPHONE NUMBER**
30 Main Street	(xxx) xxx-xxxx
CITY, STATE	**ZIP CODE**
Anytown, CA	xxxxx-xxxx

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, M.I.)		DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

Please advise status of:

- ☐ Claim for Payment. Attach a copy of form
  Date of Service _____.
- ☐ Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

- ☐ Please re-evaluate modification/denial of claim for payment. I have attached all necessary x-rays and/or documentation.

REMARKS (Corrections or Additional Information)

Sample

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

_____ _____
SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR DENTI-CAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

DC 003 (R 12/95)

Figure 3-12b
CLAIM INQUIRY FORM
(Claim Re-Evaluation Only)

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (E.O.B.)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your provider manual for detailed instructions
- For clarification call DENTI-CAL

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

BILLING PROVIDER NAME	MEDI-CAL PROVIDER NUMBER
Adams, James	Gxxxxx-01
MAILING ADDRESS	**TELEPHONE NUMBER**
30 Main Street	(xxx) xxx-xxxx
CITY, STATE	**ZIP CODE**
Anytown, CA	xxxxx-xxxx

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

PATIENT NAME (LAST, FIRST, M.I.)		DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
PATIENT MEDI-CAL I.D. NUMBER	PATIENT DENTAL RECORD NUMBER (OPTIONAL)	DATE BILLED

INQUIRY REASON - CHECK ONLY ONE BOX

CLAIM/TAR TRACER ONLY

Please advise status of:

☐ Claim for Payment. Attach a copy of form
Date of Service _____ .
☐ Treatment Authorization Request (TAR). Attach a copy of form.

CLAIM RE-EVALUATION ONLY

☐ Please re-evaluate modification/denial of claim for payment. I have attached all necessary x-rays and/or documentation.

REMARKS (Corrections or Additional Information)

Sample

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THIS PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

_____ _____
SIGNATURE DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

FOR DENTI-CAL USE ONLY

OPER. I.D. _____

ACTION CODE _____

DC 003 (R 12/95)

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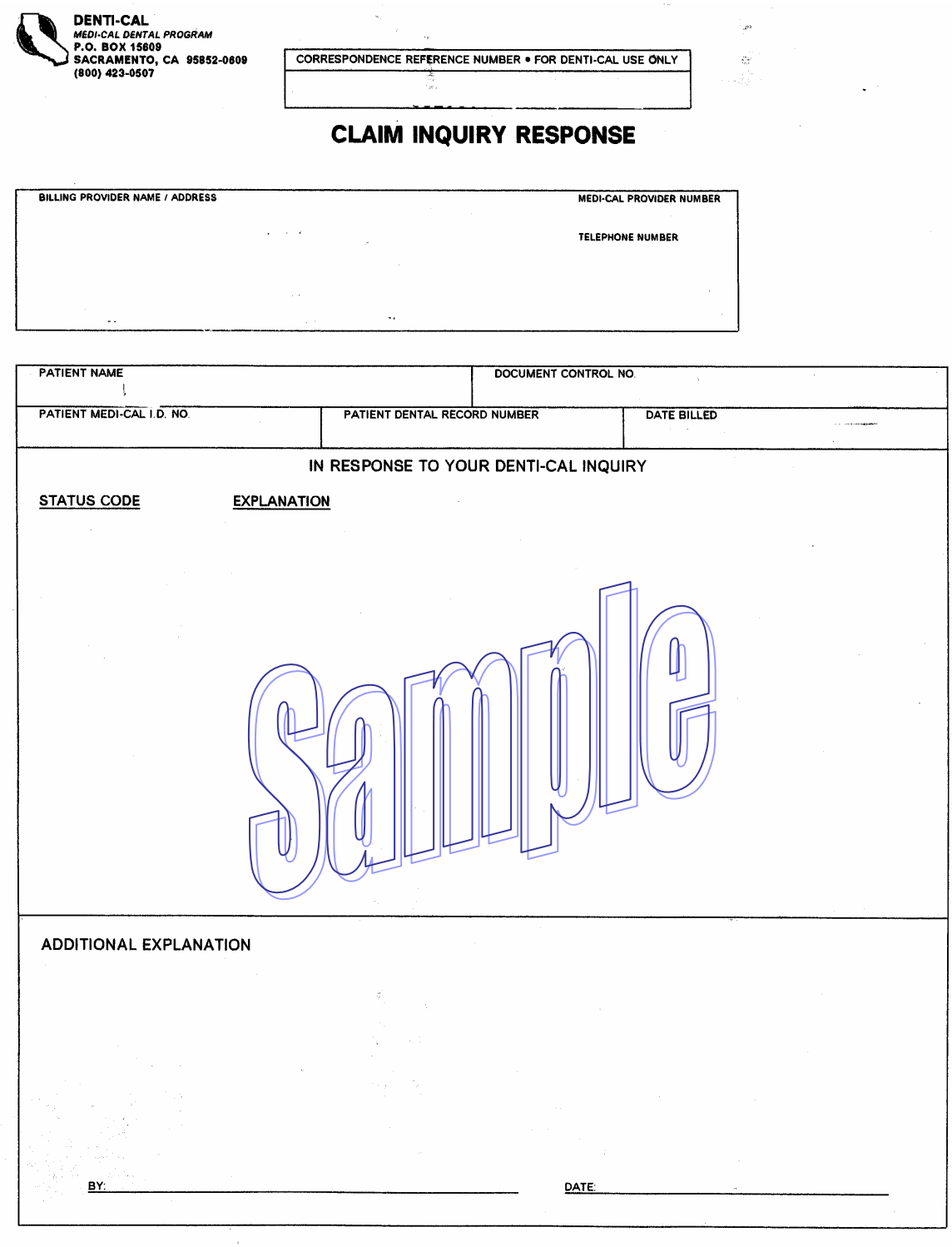
The Claim Inquiry Response (CIR)

Upon resolution of the Claim Inquiry Form (CIF) seeking the status of a claim or TAR, Denti-Cal will issue a Claim Inquiry Response (CIR). The CIR is a computer-generated form used to explain the status of the claim or TAR.

When the CIR is received, it will be printed with the same information submitted by your office and will identify the patient name; patient Medi-Cal identification number; Patient Dental Record or account number, if applicable; Document Control Number, and the date billed.

The section entitled "IN RESPONSE TO YOUR DENTI-CAL INQUIRY" will contain a status code and a typed explanation of that code. The status codes are listed under "CIR Status Codes and Messages" in Section 5 of this manual.

Figure 3-13



DENTI-CAL
MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CA 95852-0609
(800) 423-0507

CORRESPONDENCE REFERENCE NUMBER • FOR DENTI-CAL USE ONLY

CLAIM INQUIRY RESPONSE

BILLING PROVIDER NAME / ADDRESS

MEDI-CAL PROVIDER NUMBER

TELEPHONE NUMBER

PATIENT NAME

DOCUMENT CONTROL NO.

PATIENT MEDI-CAL I.D. NO.

PATIENT DENTAL RECORD NUMBER

DATE BILLED

IN RESPONSE TO YOUR DENTI-CAL INQUIRY

STATUS CODE EXPLANATION

Sample

ADDITIONAL EXPLANATION

BY: _____ DATE: _____

The Periodontal Evaluation Chart

A current and complete Periodontal Evaluation Chart is required for (1) prior authorization of Procedures 452 and 474 and (2) claim payment for Procedures 472 and 473. A periodontal chart is considered current if it is dated within 14 months of the request for treatment and no periodontal treatment has been provided after the date of the chart. Please be sure to always use the patient's current periodontal chart with your authorization request for periodontal procedures.

A complete periodontal chart must include:

- at least two numbers for facial and two numbers for lingual surfaces of each tooth;
- indication of bone loss;
- mobilities for each tooth;
- notation of missing teeth;
- indication of teeth to be extracted.

The periodontal chart must also indicate the charting date. Failure to submit a complete periodontal chart with your TAR for periodontal procedures will result in a denial of your request.

The Periodontal Evaluation Chart form DC-008 (see Figure 3-14) is provided free of charge and may be ordered from the Denti-Cal forms supplier. Instructions for completing the chart are as follows:

How to Complete the Periodontal Evaluation Chart

1. **PATIENT NAME:** Enter the patient's name exactly as it appears on the Medi-Cal Benefits Identification Card.
2. **PATIENT DATE OF BIRTH:** Enter the patient's date of birth, using the numerical format mm/dd/yy (month/day/year).
3. **PATIENT ID/SSN:** Enter the patient's recipient identification number or Social Security number.
4. **CHARTING DATE:** Enter the date the chart was completed, using the numerical format mm/dd/yy (month/day/year).
5. **PROVIDER NAME:** Enter the billing provider's name exactly as it appears in area 19 on your Claim or Treatment Authorization Request (TAR) form.
6. **PROVIDER NUMBER:** Enter the billing provider's Medi-Cal dental provider number, e.g., B12345-01.
7. **TOOTH MOBILITY:** Enter the numerical value of tooth mobility in the space corresponding to each tooth present.
8. **DIAGRAMMATIC TOOTH CHART:** Enter a minimum of two numbers for facial and two numbers for lingual surfaces of each tooth. Lines drawn to indicate pocket depths are not acceptable. Mark with an "X" all teeth that are missing. Draw two vertical lines through all teeth that will be extracted throughout the duration of the patient's treatment plan.

A copy of your office periodontal chart will be accepted as documentation if all components listed above are included on the chart. Do not send originals, as they cannot be returned.

Figure 3-14

PERIODONTAL EVALUATION CHART

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM

Patient Name _____ Charting Date _____

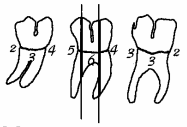
Patient Date of Birth _____ Provider Name _____

Patient BID/SSN _____ Provider Number _____

INFORMATION REQUIRED: NUMERICAL CHARTING OF POCKET DEPTHS, BONE LOSS, MOBILITIES, TEETH TO BE EXTRACTED AND MISSING TEETH. CHART **AT LEAST** TWO NUMBERS FOR FACIAL AND TWO NUMBERS FOR LINGUAL SURFACES OF EACH TOOTH.

Teeth to be extracted (# 31)

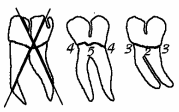
32 31 30



EXAMPLES

Missing Teeth (# 19)

19 18 17



TOOTH MOBILITY (PLEASE SCORE EACH TOOTH)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

MOBILITY
NONE = 0
SLIGHT = 1
MODERATE = 2
SEVERE = 3

Sample

FACIAL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

LINGUAL

LINGUAL

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

FACIAL

DC008 (R 7/95)

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Justification of Need for Prosthesis Form

The Justification of Need for Prosthesis Form is designed to provide complete and detailed information necessary for screening and processing prosthetic cases. This form is required when submitting a Treatment Authorization Request (TAR) for full upper and lower dentures, partial dentures and stayplates (Procedures 700, 701, 702, 703, 706 and 708). Providers should document specific information describing the condition of the beneficiary's oral condition and any existing prosthesis. Documentation must include:

- missing teeth;
- teeth to be extracted;
- teeth being replaced by the requested prosthesis (excluding third molars);
- teeth being clasped (applies to partial denture or stayplate).

It is the provider's responsibility to document conditions that Denti-Cal will need for determining the beneficiary's ability to adapt to a prosthesis. If a provider fails to submit a Justification of Need for Prosthesis Form or provides incomplete documentation on the form, Denti-Cal will issue a Resubmission Turnaround Document (RTD) for the necessary information, which will delay processing of the request.

The Justification of Need for Prosthesis Form (DC-054) (see figure 3-15) is provided free of charge and may be ordered from the Denti-Cal forms supplier. Instructions for completing the form are as follows:

How to Complete the Justification of Need for Prosthesis Form

1. **PATIENT NAME**: Enter the patient's name exactly as it appears on the Medi-Cal Benefits Identification Card.
2. **PATIENT BID #:** Enter the patient's recipient identification number.
3. **DATE:** Enter the date the patient was evaluated.
4. **PATIENT SS#:** Enter the patient's social security number.
5. **APPLIANCE TYPE:** Enter the type of prosthetic appliance the patient has or had. Indicate whether the appliance is present, the age of the existing appliance and whether the patient wears the appliance. If the TAR is for the initial placement of a prosthetic appliance, check the "initial placement" box and use the comments field to indicate the type of appliance being requested.

   If the appliance has been lost, stolen or discarded, document the date of the incident and the circumstances of the loss. The section in the lower part of the Justification of Need for Prosthesis Form has additional space for documenting details of the loss.
6. **EVALUATION OF EXISTING DENTURES:** Document the condition of the existing denture base, denture teeth, retention, opposing dentition (if applicable), vertical relation and centric occlusion. If the existing appliance is a cast metal framework partial denture, document the condition of the framework.

   Evaluate the condition of the patient's soft tissue and hard tissue (bone). If soft tissue or hard tissue is checked "inadequate," indicate the procedure that will be necessary to correct the inadequacy prior to the construction of an appliance, i.e., tissue conditioning, tuberosity reduction, excision of hyperplastic tissue, removal of tori, etc.
7. **MISSING TEETH:** Use an "X" to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers. If the arch is edentulous, check the corresponding box.
8. **PARTIAL DENTURE OR STAYPLATE:** Indicate the teeth being replaced by the requested appliance and the teeth being clasped.
9. **PROJECTED LONGEVITY AND ARCH INTEGRITY:** Enter comments regarding the general clinical condition of the arch. Consider mobility, bone loss and restorability in determining the remaining teeth offer sufficient projected longevity and arch integrity to justify the requested treatment. Document whether the patient is motivated to maintain the oral hygiene necessary to justify the requested treatment.
10. **DOES THE PATIENT WANT REQUESTED SERVICES?** After discussing the proposed treatment plan with the patient, indicate whether the patient wants the proposed services.
11. **DOES HEALTH CONDITION OF PATIENT LIMIT ADAPTABILITY?** Indicate any conditions that might limit the adaptability of the patient to wear a prosthetic appliance. Document if the condition is temporary or permanent.
12. **ADDITIONAL COMMENTS:** Use this section as necessary for additional comments or documentation specific to the requested treatment.
13. **CONVALESCENT CARE:** If the patient resides in a convalescent facility, use this field to document facility staff comments regarding the resident's ability to benefit by or adapt to the requested treatment.
14. **SIGNATURE AND LICENSE NUMBER:** The dentist completing the form should sign the form and enter his/her dental license number.

Figure 3-15

JUSTIFICATION OF NEED FOR PROSTHESIS

Procedure Nos. 700, 701, 702, 703, 706, 708

Complete each item on the form and ATTACH TO YOUR TREATMENT AUTHORIZATION REQUEST (TAR). If applicable, please attach x-rays of remaining teeth and chart missing teeth.

PATIENT: _____ BID#: _____

DATE: _____ SS#: _____

COMPLETE EACH APPROPRIATE ITEM ***PLEASE TYPE OR PRINT CLEARLY***

MAXILLARY

Appliance Requested: ☐ FUD ☐ PUD ☐ Stayplate

Existing Appliance: ☐ FUD ☐ PUD ☐ Stayplate ☐ Never Had

Wears Appliance? ☐ Yes ☐ No Age of Appliance: _____

If no, explain: ☐ Lost _____

☐ Stolen _____

☐ Discarded _____

Comments: _____

MANDIBULAR

Appliance Requested: ☐ FLD ☐ PLD ☐ Stayplate

Existing Appliance: ☐ FLD ☐ PLD ☐ Stayplate ☐ Never Had

Wears Appliance? ☐ Yes ☐ No Age of Appliance: _____

If no, explain: ☐ Lost _____

☐ Stolen _____

☐ Discarded _____

Comments: _____

	Adequate	Inadequate	If inadequate, explain:
Denture Base	☐	☐	
Framework	☐	☐	
Denture Teeth	☐	☐	
Retention	☐	☐	
Soft Tissue	☐	☐	
Hard Tissue	☐	☐	
Opposing Dentition	☐	☐	

	Adequate	Inadequate	If inadequate, explain:
Denture Base	☐	☐	
Framework	☐	☐	
Denture Teeth	☐	☐	
Retention	☐	☐	
Soft Tissue	☐	☐	
Hard Tissue	☐	☐	
Opposing Dentition	☐	☐	

	Adequate	Inadequate
Centric Occlusion	☐	☐
Vertical Relation	☐	☐ Open ___ mm. ☐ Closed ___ mm.

Edentulous: ☐ Maxillary ☐ Mandibular

1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

✖ Block out missing teeth ○ Circle teeth to be extracted

Sample

FOR PARTIAL DENTURE OR STAYPLATE

MAXILLARY

Teeth Being Replaced _____

Teeth Being Clasped _____

MANDIBULAR

Teeth Being Replaced _____

Teeth Being Clasped _____

If arch contains remaining teeth, indicate projected longevity and arch integrity (e.g. bone loss, tooth mobility, etc.): _____

If prosthesis has been lost, explain all circumstances: _____

Does the patient want requested services? ☐ No ☐ Yes

Does health condition of the patient limit dental adaptability? ☐ No ☐ Yes Explain: _____

ADDITIONAL COMMENTS _____

(CONVALESCENT CARE) Comments about patient's condition as stated by Charge Nurse / Social Services / Caregiver: _____

Provider Signature _____ License # _____

DC 054 (11/00)

Checklists Denti-Cal will only accept original State-approved forms. No duplicates or photo copies will be accepted or processed.

Please make sure all applicable areas of the forms are filled in completely and accurately. Any claim service line (CSL) submitted with an invalid procedure code or a blank procedure code field will be denied, whether submitted electronically or as paper documents. Documents received without a service office number or with an incorrect service office number listed can delay the processing of claims, TARs and increase the possibility that payments may be forwarded to the wrong office.

Before submitting a Claim form, TAR, or NOA to Denti-Cal for payment or authorization, follow this checklist:

1. Submission for Claim (Payment) or TAR. Have you...
   a. completed an original Claim form?
   b. listed the date services were performed?
   c. indicated at which service office the procedure was administered?
   d. placed X-rays only in appropriate x-ray envelope?
   e. printed or written your name, address and “Do Not Recycle” on the X-ray envelope if they are to be returned to you?
   f. included any remarks or attachments necessary to document this payment request?
   g. affixed any paper attachments on a 8.5 x 11 piece of paper?
   h. placed any attachments behind the forms and stapled it just once in the upper right hand corner?
   i. submitted only one-sided attachments?
   j. provided the appropriate signature and date in the signature block?
2. Submission for NOA (For Payment). Have you...
   a. listed the date of service?
   b. checked the "delete" column for services not performed?
   c. indicated any additions not requiring prior authorization?
   d. included any necessary X-rays or documentation?
   e. filled in all shaded areas, if applicable?
   f. affixed any paper attachments on a 8.5 x 11 piece of paper?
   g. placed any attachments behind the forms and stapled it just once in the upper right hand corner?
   h. submitted only one-sided attachments?
   i. provided the appropriate signature and date in the signature block?
3. Submission for NOA (For Re-evaluation). Have you...
   a. checked "Re-evaluation is Requested" box at upper right corner?
   b. enclosed your NOA in the blue-bordered mailing envelope?
4. Study Models

   Study models are only for the evaluation of orthodontic benefits. Study models submitted for all other procedures (crowns, prosthetics, etc.) will be discarded unless Denti-Cal specifically requested the models to evaluate the claim or authorization request.

   Study models are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment.

   As study models are not returned, please do not send originals.
5. Paper Copies and Prints of Digitized Radiographs

   Denti-Cal continues to receive numerous paper copies and prints of digitized radiographs that do not properly identify the beneficiary, the date the radiograph was originally taken, or the teeth/area in question. *This leads to processing delays as well as denial of treatment.*

   Providers are reminded that submitted paper copies and digitized prints of radiographs must conform to the following specifications:

- They must be properly dated with the mm/dd/yy the radiograph was originally taken. This date must be clearly discernable from other dates appearing on the same copy such as the date the copy was made or printed, or dates of previously stored digitized images.
- They must be properly labeled with both the beneficiary's name and the provider's name.
- Copies or digitized prints of full mouth series radiographs and panographic films must be labeled "right" and "left." Copies of individual films or groups of films less than a full mouth series, should have the individual tooth numbers clearly identified.
- They must be of diagnostic quality. Many of the copies/prints Denti-Cal receives have poor image quality as a result of poor density, contrast, sharpness, or resolution, and are, therefore, non-diagnostic. The image size should be the size of a standard radiographic film or larger. By reducing the image to be smaller than the size of a standard radiographic film, the diagnostic quality is compromised.

Providers should review copies/prints before submitting to Denti-Cal to ensure the images are of diagnostic quality.